STATE OF ILLINOIS

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

DIVISION OF INSURANCE

IN THE MATTER OF THE MEDICAL MALPRACTICE RATE INCREASE OF: HEARING NO. 05-HR-0771

ISMIE MUTUAL INSURANCE

-and-

IN THE MATTER OF THE MEDICAL MALPRACTICE RATE INCREASE OF: HEARING NO. 05-HR-0772

ISMIE INDEMNITY COMPANY

Public Hearing held, pursuant to Notice, on the 27th day of September, 2005, at the hour of 9:20 a.m., at 320 West Washington, Springfield, Illinois, before Michael T. McRaith, Director of Insurance.

CAPITOL REPORTING SERVICE, INC.
2021 TIMBERBROOK DRIVE
SPRINGFIELD, ILLINOIS 62702

PROCEEDINGS

DIRECTOR MCRAITH: Good morning. This is the public hearing on the rate filing -- rate filings of ISMIE Mutual Insurance Company and ISMIE Indemnity Company, Hearings No. 05-HR-0771, 0772. The hearing is conducted pursuant to the relevant provisions of the Illinois Insurance Code.

Welcome to the Illinois Division of Insurance and our Springfield home at 320 West Washington Street. I'm Michael McRaith, Director of the Illinois Division of Insurance, and I'll be the hearing officer for this, the first public hearing on medical malpractice insurance rates as provided in the recently enacted reform legislation.

Before we begin, I want to recognize certain Division of Insurance employees who assisted with preparation for this hearing, and who repeatedly demonstrate the many reasons that the Illinois Division of Insurance is so highly regarded throughout the country. At the risk of excluding someone, I do want to individually acknowledge Sarah Fore, Judy Pool-Boutchee, Pam Donnewald, Jack Messmore, Gayle Neuman, Karen Hoffert, Bog Wagner, Tim Cena, and Mike Hessler. These are skilled

professionals who have for years been dedicated to the mission of effective insurance regulation, and as a state we are indebted to these great employees. I have asked them to sit nearby as this hearing unfolds so that I can receive the benefit of their analysis, and so that they can have the firsthand benefit of this experience upon which the Division can build for the future.

For the hearing today, we will begin with the presentation by, and examination of, ISMIE Mutual Insurance Company; then allow for interested parties to present; and then, if necessary, we will re-call ISMIE to answer any additional questions or present additional information.

We intend to move through this process efficiently. I will ask questions. Witnesses cannot ask questions of one another. In other words, one witness or interested party will not cross-examine another. For those of you who will testify, we ask that your statements and answers be concise and complete. To the extent that any statement appears to be duplicative or cumulative, then we politely, but firmly, will bring that statement to an end.

We intend to conduct this hearing with all

appropriate professionalism, and while we certainly do not expect any unruly behavior, we do have security guards in the be building and on call. If you need to leave the room during the proceedings, please do so quietly. When you enter or leave this room, please do not wander around this office, floor, or any other place in the building.

Finally, I want to thank you for your attendance and your participation today. This is the first hearing of this type in state history. While we do not have any Illinois-based precedent, we have worked hard to fashion a hearing structure that will account for and effectuate the priorities of the recently enacted reform legislation. These priorities were established after months of General Assembly debate and hearings that followed a very large rate increase from 2002 to 2003, and subsequent characterizations of a crisis due to high insurance rates for healthcare professionals. We understand that at bottom this discussion involves the people in Illinois, and whether they have accessible, affordable, and quality healthcare.

The Illinois Insurance Code now reposes in the Division the authority to hold a public hearing

on proposed medical malpractice insurance rates to determine whether the rates are excessive, inadequate, or discriminatory, and while these are broad concepts, we have very specific questions to determine whether the rates charged by ISMIE Mutual Insurance Company satisfy the statutory criteria.

At times this discussion will be technical and extremely boring for those of us who do not feel a thrill as we discuss actuarial concepts. The topics will be downright bland at times. However, we expect that the discussion will also include important dialogue regarding ISMIE's business and rate-making practices.

Again, our sole purpose is to determine whether the rates satisfy the statutory criteria and are not excessive, inadequate, or discriminatory.

With that, if you're ready, I invite ISMIE and its representatives to begin their presentation.

MR. WASHBURN: Thank you very much, Director.

MR. WAGNER: Do you want to ask the court reporter to maybe swear in the panel?

DIRECTOR MCRAITH: Yes. In fact, before -- we'll just do -- I'd ask the court reporter to swear

in all who will testify on behalf of ISMIE this morning. We can do one oath. Ms. Court Reporter, would you do that?

(All potential witnesses for ISMIE were duly sworn.)

DIRECTOR MCRAITH: Thank you.

MR. WASHBURN: Thank you very much, Director. My name is John Washburn. I'm senior vice president for ISMIE Mutual. As part of the record, I would like to put into the record these two volumes here. They basically include a great deal of material you already have, which is our rate filing for the 2005-2006 year, but it also includes our -- a written version of our statements today and some additional actuarial information that was not part of the original filing.

We thank you for the opportunity to come here today.

DIRECTOR MCRAITH: I'm sorry to interrupt, John. Could we get a copy of that then?

MR. WASHBURN: We've got copies for you.

DIRECTOR MCRAITH: Great.

MR. WAGNER: Can ask the court reporter to mark these as --

DIRECTOR MCRAITH: Why don't we mark these as --

DR. CLEMENTI: Are they the same copy, John, or --

MR. WASHBURN: Yes, they are. They're --

MR. WAGNER: Oh, two of the same. That's Exhibit No. 11.

DIRECTOR MCRAITH: No, why don't we call these Respondent's Exhibit 1.

(Respondent's Exhibit No. 1 was marked for identification.)

MR. WASHBURN: We thank you for the opportunity to come here and explain our rate-making process. Our hope is that this hearing will help to clear up the information, and some of the misconceptions that have swirled around this process over the last several years.

I have with me a group of people who are intimately involved in the rate-making process for ISMIE Indemnity and ISMIE Mutual. The process is exactly the same as the rates are the same for both companies. I would like to introduce them now. On my right is Dr. Clementi. Dr. Clementi was involved in the formation of ISMIE. He has been involved in

the running of this company for over 30 years, and is currently chairman of the board of the company that provides the underwriting and management services for ISMIE Mutual. Next to him is Bud Gross. Bud is the chief financial officer for ISMIE, and he has been in that position for over 15 years. In addition, I have from ISMIE Mutual's staff, I have Al Allphin. Al is behind me there, and he is the head of underwriting, and has been with ISMIE Mutual for 18 years. We also have here Saul Morse. Saul has been the legal counsel for ISMIE since 1977. Additionally, we have the three actuaries who are most involved with ISMIE Mutual. We have John Meeks, who is the -- who is the in-house actuary, and has been with ISMIE since 1995. We also have Dave Bickerstaff of Bickerstaff, Whatley, Ryan & Burkhalter. Dave has been the actuary for ISMIE Mutual since the startup of that company. And last, but certainly not least, we have Tom Conway of Ernst and Young. Tom is with Ernst -- has assisted ISMIE in their analysis of the rates and the rate-making process for over 15 years. The actuaries are here, certainly, to answer any questions that you may have over the actual rates that we came up with.

I think it's very difficult to understand sort of ISMIE Mutual's structure and its system without really understanding the genesis, and so I think we would like to have Dr. Clementi sort of go through how ISMIE got started, and where it is today. Doctor.

DIRECTOR MCRAITH: Could I ask, can people in the back of the room hear up here? Okay.

DR. CLEMENTI: As mentioned by Mr. Washburn in the introduction, my name is Alfred Clementi. I'm a general surgeon, and am currently chairman of ISMIE's day-to-day operation manager which is ISMIS, Insurance Services. I may use that term periodically through my presentation.

I was on the board of the Illinois State Medical Society back in 1975, 30 years ago, when the then major liability insurance company, the Hartford, served notice in its intent to raise rates by 200 percent. It subsequently left the market altogether.

Faced with physicians being unable to practice medicine because of the crisis, Hartford's -- crisis of Hartford's action, the Illinois State Medical Society looked at starting up a company that would respond to the medical liability

insurance needs of the physicians. As a result, ISMIE was born. It began writing professional liability coverage in July 1st of 1976. Initially, called Bedpan Mutual, that was what all the commercial carriers called us. There are 35 of us now, physician-owned or operated companies, throughout the United States, and it was for this purpose that we developed the program. The key hallmarks then and today are still availability, stability, and security. Last, of course, is secure -- last, of course, is key as essential -- essentially, we promise to be there for our policyholders by providing claims defense and meeting our obligation to them when they need it.

Over the last 30 years, as our experience has grown, we've fine-tuned our process, whether they be in claims or underwriting or in risk management. Also in the past 30 years, we've experienced a number of market challenges. Despite these challenges, ISMIE's 30-year presence in the otherwise turbulent market has been stedfast. We've kept our commitment to writing insurance, covering all areas of the state and all medical specialties. This stands in stark contrast to many of our competitors, many of which

have fled or went bankrupt because they grossly underestimated the complexity of this business, and the problems that liability within the State of Illinois have incurred. Ten years ago there were over 30 companies writing medical liability in Illinois. Now, in addition to ISMIE, there are only a few, and there is a graph that we have to illustrate these five top carriers.

Finally, probably one of the most important things that has remained constant since ISMIE was begun is the physician management and physician involvement in all aspects of the company. It is a physician policyholder like myself who comprise the board of ISMIE Mutual, its subsidiaries, and all of its key committees. It is physicians who set the company policy and direction. It's physicians who are involved in the underwriting and claims decision, and it's physicians who are involved in the design of our nationally recognized risk management program.

Lastly, it is the physicians who are involved in determining our rates, and we do mean our rates because, obviously, each of us is policyholders. This is very important as it means that every policy decision is made by physicians who

are policyholders. Unlike other companies, there are no stockholders, so ISMIE is not profit driven. Rather, the owners are, in fact, each single policyholders. Because of this, decisions are made with only the best interest of our physician colleagues in mind, and our promise to them that we'll be here for the long run. That promise is grounded in our entire operation, our philosophy, including our rates. We're prudent, we're cautious, and we're conservative because we take that promise seriously.

For this reason, our policies cover different risks, protecting physicians from various groups. We insure individual physicians, we insure clinics, corporate partnerships, Allied Health Professionals, Medicare investigations, deposition assistance in IDPR proceedings.

Now, for some discussion on this and the actual process of rate setting, I'm going to turn this over to our chief financial officer, Mr. Gross. Bud.

MR. GROSS: Thank you, Dr. Clementi. I'm Bud Gross, CFO of ISMIE, and I'm going to go through the rate process, but first, what I wanted to do is

to give you a perspective of ISMIE's financial environment, and where they fit in there. As you know, ISMIE is a mutual insurance company. As Dr. Clementi indicated, physician owned, and writing medical malpractice and exclusively medical malpractice to physicians in Illinois, primarily. And this is a long-tail business, as you know, and that simply means that it can take several years from the time a claim or an event occurs and a claim gets reported and ultimately closed. And during that time, there's significant lag between the sale of the policy and the actual payments that are made, so there's a lot of uncertainty and unpredictability. During that period of time, a lot of things can happen, you know, inflation. Social acceptance of higher claim payments can have an impact on claims that are sitting out there during that time as well, so we have to be very cautious.

And as an insurance company, as most insurance companies are, we are rated by A.M. Best who is considered an industry expert, and in 2003, they actually downgraded ISMIE two times, the security rating of ISMIE, primarily because of adverse loss development and the increasing leverage

that was happening, you know, within the company's financial position. ISMIE is currently rated B+ by A.M. Best with a negative outlook, and that negative outlook mainly means that they are monitoring ISMIE's capitalization and its commitment to adequate pricing reserving, and they stand ready to take -- to react if they see any negative implications that arise. So we're always having them look over our shoulder in that regard.

And so as a medical malpractice insurer rated by A.M. Best, it's important for us to measure our performance compared to other companies in our industry, as well as the whole P&C industry, and so what we do is, we have several key measures, and we're going to share those with you here, as to where ISMIE stands relative to its peer group of companies as A.M. Best has defined it, and then also the P&C industry in total. What you can see here is --

DIRECTOR MCRAITH: Excuse me. Are we going to get copies of the Power Point slides?

MR. WASHBURN: Yes, they're in there.

DIRECTOR MCRAITH: They are. Okay.

MR. WASHBURN: They are in the testimony

DIRECTOR MCRAITH: Okay. Excuse me.

MR. GROSS: Sure. In terms of return on surplus, you can see that ISMIE lags the competitors, the med mal companies, as well as the industry in total. ISMIE's return on surplus for 2004 was 5.9 percent; whereas, the group of med mal companies in total -- and there's 35 or 40 some. We have a list in there of the companies -- was at 9.6 percent, and the whole U.S. P&C industry was at 14.2. What's more significant, though, is to look what's happened over the five-year period. During this five-year period, very volatile in terms of losses, ISMIE had a negative return of 2.0 for that five-year period; whereas, the med mal composite was 1.1 percent positive, and the industry as a whole was at 3.4. And so it's clear from that that ISMIE has been lagging the industry in terms of its financial performance.

The next slide is net underwriting leverage, measuring the same -- ISMIE against the peer group and the P&C industry. You will see -- first of all, I'll explain. Financial leverage is measured in terms of ratio of premiums and reserves to surplus, and these are on a net basis. And ISMIE has a leverage ratio of 4.9 to 1, virtually $5 of risk for

every dollar of its policyholders' surplus. And the reserve portion of that leverage is 3.8 to 1, and that is double what the peer group is, and it's more than three times what the industry's leverage is for reserves to surplus.

You can -- to put it another way -- and that does indicate the higher the risk, the less cushion there is, you know, that our surplus is going to be there to be able to handle the risks that evolve over time. And just for ISMIE to be at the same level as our peer group of companies, it would need $160 million more of policyholder surplus, which is equivalent to 38 percent of our current premiums.

The next is a combined ratio, and this is what dictates the company's underwriting performance on an annual basis. We're also showing the five-year average, too. And the combined ratio is the adequacy of premiums to cover losses and expenses in the period, and it's computed as the sum of losses and loss adjustment expenses incurred to premiums earned and the expenses incurred to premiums written. ISMIE's combined ratio for this past year was 114.3 percent; whereas, the peer group was at 105.6 percent, and the P&C industry was actually under 100

percent at 98. And if you look at the five-year average during this period, ISMIE's combined ratio was at 126.2 percent, substantially higher than both the peer group and the P&C industry. And just in 2004, for ISMIE to have the same combined ratio as the peer group of companies, it would have had to have charged 8 percent more premium for that year.

With that in mind, I'd like to go through the rate-making process, and make some general comments, things that we consider when looking at the importance of trying to get it right at the beginning. Because of this being a long-tail business -- and this slide up here shows you how long it takes for losses to get paid on several years beyond the year that the coverage actually applies. The bottom, which you can barely see, the red at the bottom is the claims that are paid in the first year of coverage, and that's generally around 2 percent. In fact, it takes you into the fifth year before you're getting to the point where you've paid out half of what's going to be paid for that year, and as you can see in that first column for '98, we're seven years out, and we still have over 10 percent of the claims that have not -- have yet to be paid for that

year, or resolved and paid.

So as I had indicated, we only have one chance to be able to get the premium we need to cover everything that's going to happen over that long period of time, so we take it very seriously. Because of that, we do engage two independent actuarial firms: Bickerstaff, Whatley, Ryan and Burkhalter as our certifying actuary, and Ernst and Young as our consulting actuary. And they work closely with our in-house actuary, John Meeks, who coordinates the whole process of pulling together -- sharing the data with them and pulling together their results.

The loss data is analyzed at least quarterly, and it's monitored on a continual basis. The September 30th data each year is used to perform a comprehensive relativity study to determine the appropriate way to separate the risks by specialty -- physician specialty and by territory, and that is incorporated into the final rate study which is done after the 12-31 loss data is put in, in the review. And David Bickerstaff is actually -- as our certifying actuary, does provide us an actuarial opinion on our loss reserves each year, and he also

signs the rate filing that's filed effective for all policies that renew after July 1 each year. But Tom Conway goes through the same process to review rates and relativities and reserve indications.

Now, the rating process begins by providing each actuary all the comprehensive data of claims and exposures, and there are meetings with the actuaries along the way to discuss any relevant environmental issues or procedural changes that they would need to know that could possibly impact the way to analyze the data or how claims are going to be handled so they can help -- that can help formulate their projections.

Once they have gotten their reports, they meet with ISMIE staff to go through their indications and the basis for their selections, and once we compile everything and evaluate it ourselves, also, all of this is presented to the Rates and Reserves Committee of the Insurance Services company, which, as Dr. Clementi had indicated, is comprised of all physicians and all policyholders. And they actually -- they get the reports from each actuary, and they also have an opportunity to hear a presentation from the actuaries and ask any questions

that they may have. And after that process, they bring a recommendation up to the Insurance Services board, which, in turn, brings it forward to the ISMIE board before final approval. So it does go through three levels of physician review before the final decision is made on rating, and then notification to policyholders begins.

So with that in mind, what I'd like to do is go through the elements of the rate development, most of which are actuarially driven, and I'll describe, you know, how they look at that, but if there's any questions later, of course, they're here to respond.

DIRECTOR MCRAITH: Okay. How long do you anticipate your -- the initial presentation taking, Mr. Washburn?

MR. WASHBURN: I believe other 15 minutes.

DIRECTOR MCRAITH: Okay. Great. Okay.

MR. GROSS: Okay. What I'd like to do, the very top line is the frequency per Class 5 equivalent. Class 5 is internal medicine, and this would be an internal medicine doctor in Chicago, for instance, because that would be our largest concentration of policyholders, and the frequency factor is developed by the actuaries. That would be

the expected number of claims per physician that would come in during this period, and what they -- you know, this number can go up or down from year to year, but it usually tends to fit a trend line that they're comfortable with. So when they make a recommendation, it's based on their best guess of what's going to happen.

The next line is the indemnity, the average indemnity that we're going to pay on a million dollar limits policy, and that number is also factored the same way, looking through all of the loss data, trending it, and building in all of the levels that they need to, to come up with their number.

The overall expense severity is what we expect to incur in defense costs for claims that are going to be reported during that period. This would include claims that close with indemnity, as well as those without. The next two percentages show what we expect. We expect 17 percent of the claims to close with indemnity, and 73 percent to close with just expense. So 90 percent will close with some sort of payment. If you can take -- the formula, take the indemnity times the CWI percentage, and the expenses times the combination of the CWI and CWE percentage,

and that will give you the average cost per claim, which is the next line.

And then the next line is taking that cost and multiplying it by the frequency, and that would be the cost per exposure. And this, like I say, is all input from the actuaries.

The next line, the present value factor, is our way of discounting that premium down based on the fact that we are going to collect investment income between when we collect the premium and we pay the claims, and so we want to give our policyholders credit for that investment income that we're going to earn. So that number will include a couple of things. It will include the actuaries' determination of what that payout pattern or payout trend is going to be, and what we think that our investment income can be on that.

I think next we'll go through administrative factors. The next one after that. Okay. What I've put here is the different elements of the rating that are looked at that we have to load in, in terms --

DIRECTOR MCRAITH: Mr. Gross, could I ask you to hold on one second? Where do we find the Power Point slides in the binder?

MR. WASHBURN: They're in Section 3.

MR. GROSS: And 4.

DIRECTOR MCRAITH: Which Section 3 and 4?

MR. WAGNER: It starts with the background.

DIRECTOR MCRAITH: Okay. Thank you.

MR. GROSS: This is on page ten. What this shows is the various expense components of the rate development. We do have some expenses that we consider to be fixed. In other words, every policy will probably incur that amount of expense on a regular basis, and that number has stayed pretty steady. We also have expenses that vary according to the risk level of relative risk exposure. We have costs of managing claims that gets factored in. We have investment-related expenses that we need to cover. Marketing expenses, as well as fees paid to producers, that need to be built in, and regulatory fees and guaranty fund assessments, things like that, that we need to take into consideration.

Over the course -- we're still on that slide before that. During the course of the five-year period, most of our expenses have gone down in relation to the exposures. The only item that has gone up in the last couple years is under the

regulatory and assessments, and that's primarily because of guaranty fund assessments that ISMIE has to pay for insolvent companies that have been in Illinois in this business and are no longer able to meet their obligations. And since ISMIE is a significant writer of this business in Illinois, it shares a very large portion of that cost.

The next slide shows what our direct expense ratio is relative to the composite of medical malpractice companies and the P&C industry, and it's broken down by the different types of expenses that are indicated there. But as you can see, in total, ISMIE's direct expense ratio is 13.5 percent, which is well below the medical malpractice composite of 18.0, and the industry composite of 29.2 percent. In fact, ISMIE is behind on -- is lower in the general underwriting area and unallocated claims area. It's slightly higher than the medical malpractice composite on the direct commissions, and it's not because we pay our brokers more, it's just because two thirds of our business is actually written by brokers.

Another important factor in our rating process is the discount off balance because ISMIE

must collect enough premium in total to be able to provide the types of discounts that -- where appropriate, and we have two primary -- three, now, primary discounts that are offered. We have schedule rating for economically integrated groups, and that is done based on underwriting's careful review of the loss exposure on a group basis. And that process is also reviewed by our actuaries to determine that the credits that are given and that basis are justifiable and fairly applied. A big component of our loss is -- loss-free discount is a big component of our off balance as well, and that's a type of program that's available to all policyholders, including individual policyholders, based on loss-free experience, and it's pretty generous in terms of the type of discount that's given, you know, when a physician can go several years without losses.

Most recently we've added a risk rewards credit, which, again, is available to individuals, as well as members of groups, where a physician can earn credits based on the amount of risk management programs they participate in because we feel very strongly that risk management is important to the process of making sure that, you know, physicians can

protect themselves. And we think that the clinic or the group rating is -- has come down over time because we are introducing the risk management program rewards that, you know, can offer everybody, you know, something like that.

The contingency margin is another thing that we have to factor into our rate. For the last four years, we've used a contingency margin of 9 percent. That contingency margin has to cover a lot of uncertainties because this business is very uncertain. What we've used the majority of this margin for over time, and particularly in the last few years, is to fund our reinsurance costs, and -- because there's a lot of uncertainty that we like to share, you know, with some other company, if we can, and the reinsurers have been very -- have worked very closely with us. We've had a good working relationship with them. They've helped us put together programs that provide us the best protection that we can, but it doesn't leave us much within that margin to be able to cover any other uncertainties that can arise.

And as you'll see on this next slide, the loss ratio that ISMIE had for the five years -- we've

got four years. 2000 through 2003, you can see that ISMIE's loss ratio that was expected when it did its pricing was at the 90 percent level, and it's really been running more in the 120 percent range for that period. So in order for us to be able to cover that, our contingency margin, obviously, was not enough, and in a situation like that, the only way we can fund that difference is out of the company surplus.

Okay. What we've got here, kind of putting it all in perspective in dollars and cents, is a summary of what ISMIE needs in order to be able to get a target return on its surplus, which would keep it in pace with the loss trends. And the projected premium we have, which is based on the whole rating formula and the number of exposures we have currently, is a projected premium of $403 million for this policy year period because our actuaries are telling us that we expect to have 249 million of indemnity claims that will apply to this coverage period, and it's going to cost us $85 million, ultimately, to defend cases that come up during this period, and those combined is 334 million of that 403. ISMIE's budget process tells it how much it needs in terms of monies to cover its expenses, its

claims management expense, its administrative expenses, its expenses that it pays for marketing and commissions to producers, and for regulatory assessments, and that totals up about $64 million there, which leaves an underwriting result of about $5 million. So out of that 403 million, we only expect to retain 5 million, but in order to protect ourselves, we also need to purchase reinsurance, and that reinsurance cost is $31 million, which leaves us on a net underwriting result of negative $26 million on -- built into this whole pricing process.

We anticipate investment income during this period from all sources to be about $40 million, and after taking in investment income, we would expect that we would pay about $5 million in income taxes, which would leave us with a net contribution to policyholders' surplus of $9 million, which is only about 2 percent of our premium, and that $9 million would represent about a 4 percent return on policyholder surplus.

So, again -- and anyone that thinks that 2 percent is enough, you know, should look at some of these prior years where you can see the vast difference between the loss ratio we expected and the

loss ratio that we have actually had.

MR. WASHBURN: With that, Director, we're sort of done, you know, on the main filing of the rates. If you would like us to go into how we do the specialization and classes, we can do that, or we can stop for questions right now.

DIRECTOR MCRAITH: We'll have a lot of time to talk about the classes and specializations and that kind of thing. I do have some -- is that your initial presentation, Mr. Washburn, that you're doing?

MR. WASHBURN: Actually, we sort of split it up into this is sort of the rate filing per se, and then we were going to talk about how we determined classes and territories. We can do that now -- continue now and finish that, or we can talk about the rates now, or it's really up to you, Director.

DIRECTOR MCRAITH: We'll talk about classes and territories as the day proceeds, and you'll be able to explain all of that in response to the questions that I have, I expect.

MR. WASHBURN: We thought it might be helpful if we just spend a couple minutes going over how we come up with the classes and territories.

DIRECTOR MCRAITH: How long do you expect that to take?

MR. WASHBURN: Probably 10, 15 minutes.

DIRECTOR MCRAITH: Sure. Why don't you go ahead and do that now, and then is that the end of your formal presentation?

MR. WASHBURN: That will be the end of our formal presentation.

DIRECTOR MCRAITH: Okay. Good.

DR. CLEMENTI: Thank you, Mr. Chairman. There are a number of key elements, talking about territories and classes, in our view toward the rates of territories and the specialty classes. Our objective in this is to be as thorough as possible for some very important reasons. First, as physician owners and managing the company, it's important that we have equity among our policyholders in terms of payment. There are some, specifically the trial attorneys, who would have the opinion that costs of medical liabilities insurance should be socialized among all policyholders regardless of where they practice or what their specialty might be. We believe that this approach does not assist in driving good medical practice, and I'll come back to these

points when I give some examples of the classes later on.

The second important reason we want to make this process as accurate and equitable as possible is the rate -- rates are determined assuming our book of business does not change. We know that there is no such constant in this business. As experienced significantly during the last soft market, competitors will come in and try to take pieces of our book or territories, specific specialities that they think are less risky. Therefore, we need to assure our rates are adequate for the book of business we have. To do this, we need to know how the rates -- how to rate the risk of business as it's written on an individual basis.

The changes in territories or specialties are discussed by the Insurance Services committee, Rates and Reserve Committee, each year. Often our actuarials bring to us the needed areas of change of attention, and along with our own rate committee, our PRC committee, which is a review committee of claims, and our PREP committee, which is one that helps underwriting, each of these is involved in a different aspect of the activities.

As these committees and rate committees are all physicians, the discussion often involves medical practice, as well as actuarial consideration. There's no doubt in my mind that the breadth of medical experience available in ISMIE provides this company with a significant advantage in making good decisions among the classes and specialties.

Throughout the years since our establishment in 1976, we've had a number of changes in how we look at both territories and specialty classes. Let me give you some examples. As you may be aware, we started off with seven categories. There were seven classes of physicians, and at the present time, we've moved that to 20, and the reason we've done that is because we've seen within specialties differences that require differences in rating. For example, the old obstetrics and gynecology, one of the larger groups, used to be in Category 6, 6 of 7. As time has progressed, we've seen that there are differences between those who do all risks ob/gyne, those who do only major risk -- or do no major risk, those who do just gyne, or those who do gyne surgery, or maybe somebody who does -- works in the office. Each of these groups have a different risk, and each of them

should be rated differently. And so we classified them differently, and we have them ranging now from Class 8 all the way up to Class 16. So we have a wide range of these particular divisions, and it's because of trying to establish an appropriate rate.

Another example is what we did with bariatric surgery. As you know, that's for those who are excessively obese. This group of people, the people who are doing this surgery, were general surgeons. It is a general surgical procedure, but as was found back in the '80s, there were certain risks associated with the surgery, and these, with time, became more evident. They did develop some liability associated with them, and those who were doing bariatric surgery were rated in a higher class. So they were higher than the general surgeons. As time progressed, more specialization, better care, and improvement in the care of those individuals, that group has now moved back into the general surgery group. So each one of these has changed up and down over a 10-, 15-year period depending upon what's going on in medicine.

Anesthesia is another example. Anesthesia used to be classified in one of the highest

categories with ob/gyne. They were Class 6, and with time, anesthesia, because of their monitoring processes, because of what they've been able to do in improving the delivery of care, they've gone down to lower than any of the other surgical specialties.

I can give you a lot of other examples, urology surgery, ER physicians, neonatology. All of these different groups, these different specialties, need to be rated differently.

And, of course, what we do with territories is pretty much the same thing. We look at what is happening in that particular territory, and try to establish what the losses should be. Our system of category risk -- categorizing risk has evolved over the years to be fair and accurate as possible. As a physician-owned company, we have an edge in evaluating the classified medical risk because we know the medicine. However, we do not make changes easily or quickly. For example, a one year of bad risk doesn't mean that we change the rates. It may take two or three years before we see a trend, and we see a need for changing a territory or changing a specialty.

And because we are a physician-oriented

organization, unlike other companies, we actually have a process in place where we warn territories. We tell groups that there has been an increase in their area. If they can establish or identify what it is, it would be to their advantage. We're going to be watching them over the next two or three years so that they know the potential or the possibility of change.

We have the actuaries here today, and they can answer any questions that you have about analyzing the differences among territories. If there are any particular questions that you have at this time, I'll be glad to answer them.

DIRECTOR MCRAITH: Okay.

MR. WASHBURN: Once a territory rating is done, we've still got to -- we've still got to get it ready for the underwriting, so I thought I'd bring Al up and just talk a couple seconds about how that all gets translated into what gets quoted to a doctor.

DIRECTOR MCRAITH: Sure.

MR. ALLPHIN: Director, may I stand?

DIRECTOR MCRAITH: Sure.

MR. ALLPHIN: There's a graphic that shows the premium calculation, how we start with a base

pure premium, which is 20,540, to which we add a factor for death, disability, and retirement. We offer a claims-made product, and the reporting endorsement is issued without cost under those circumstances, but that does cost all the policyholders something since that is a benefit, so that is the amount that we factor into the rate.

This involves the calculation of our base rate for internal medicine, no minor risk procedures, Cook County, mature premium, one million limits. So the territory relativity factor is one because Cook is the base county against which we measure the other relativities of the counties. So that's times one. Then we apply the class relativity factor, which, in this case, is one because internal medicine is the base class. And we multiply the unallocated loss adjustment expense factor, which is a claim management expenses, which is 1.045. We then multiply the variable expenses, which includes commissions and taxes, which account for the other expenses of operating the insurance company. And then there's a fixed expense factor of $725 that is added. The contingency load is then a division, which is 1 minus .09, and then the provision for

discounts is again a division, it's 1 minus .248, and that reaches what we would consider the manual rate for internal medicine. This is the published rate. This is the rate that if a physician called up and we knew nothing more than the physician's specialty or where he or she practices, this is the amount that they would be given without any other underwriting information.

Go to the next one. This is a rate comparison of the -- of selected specialties and ISMIE versus its most significant competitors in Illinois. The selected specialties represent about 57 percent of ISMIE's insured physicians. The blue numbers indicate who is the lowest. For example, we're lowest in anesthesiology. These rates are Cook County, mature, one million/three limits. And as you can see in most instances, not a hundred percent, but in most instances, we are our -- our manual rates, the ones that we publish, are less than those of our competitors.

MR. WASHBURN: With that, Director, we are done with our presentation.

DIRECTOR MCRAITH: Thank you, Mr. Washburn. I have a couple initial questions about some of the

Power Points. Mr. Gross, in the slides that you talked about, you referred to competitors or similarly situated companies. Do you remember those comparisons and those slides?

MR. GROSS: Uh-huh.

DIRECTOR MCRAITH: Were those comparisons to other P&C companies?

MR. GROSS: Yes. Those competitors were actually physician -- or medical malpractice insurance companies, mostly members of the PIAA, but they're companies that A.M. Best determines to be in the same niche as ISMIE is, and that's what they measure us against.

DIRECTOR MCRAITH: So that's what the rating company measures you against?

MR. GROSS: Yes.

DIRECTOR MCRAITH: Are they nonprofit carriers?

MR. GROSS: For the most part. Well, there's some stock companies in there, companies that used to be companies -- you know, mutual companies and became stock companies, or some that consolidated together and went into other states, but --

DIRECTOR MCRAITH: So the comparison

includes for-profit, publicly owned companies. The comparison then would also include -- does it include other nonprofit companies?

MR. GROSS: Yes.

DIRECTOR MCRAITH: It does. Do you know what percentage are nonprofit and what --

MR. GROSS: Mutual insurance companies, you mean?

DIRECTOR MCRAITH: Right.

MR. GROSS: Yes.

DIRECTOR MCRAITH: Do you know what percentage are publicly traded?

MR. GROSS: We've got a list in here. I'm sure that it's more than half of them are mutual insurance companies.

THE REPORTER: I'm sorry, I can't hear you.

MR. GROSS: More than half of them are mutual companies. I'm sorry.

DIRECTOR MCRAITH: Are there other -- do you know, in the comparisons, are there any other insurers that have one line of business in one state?

MR. GROSS: For the most part, those would be one line of business. They may be in more than one state.

DIRECTOR MCRAITH: Okay.

MR. WASHBURN: But mutual companies aren't for profit. They just are not stock. They don't have stockholders.

DIRECTOR MCRAITH: Right. I understand.

MR. WASHBURN: As I go through the list in my head, I cannot think of a not-for-profit company in this business.

DIRECTOR MCRAITH: Well, is there -- what's the percentage of mutual companies versus publicly trade companies in the comparisons that Mr. Gross referred to?

MR. WASHBURN: I don't have that number. We'll get that for you.

DIRECTOR MCRAITH: Okay.

MR. GROSS: We can take this list, and we can very quickly identify which ones are --

DIRECTOR MCRAITH: And can you let me know what percentage of those companies -- or what number of those companies are also one line of business in one state?

MR. WASHBURN: Very few. I mean, we --

DIRECTOR MCRAITH: Other than ISMIE.

MR. WASHBURN: We would not consider

ourselves to be one line of business in one state. We do have some business in some of the surrounding states. It's very little, but we do have business in some of the surrounding states.

DIRECTOR MCRAITH: When you say very little, what percentage?

MR. WASHBURN: I wouldn't know the percentage. We could get that to you, too, but it's quite small.

DIRECTOR MCRAITH: Less than 5 percent?

MR. GROSS: It's less than 1 percent.

MR. WASHBURN: Less than 1 percent.

DIRECTOR MCRAITH: Less than 1 percent. So that's really -- for all intents and purpose, ISMIE is one line of business in one state; right?

MR. WASHBURN: Right.

DIRECTOR MCRAITH: Okay.

MR. GROSS: So we can use a similar comparison as we go through some of these other companies.

DIRECTOR MCRAITH: Well, I'm just trying to get a sense of whether the comparison is an accurate comparison, or are we looking at apples and oranges. That's why I'm asking these questions. So is the --

does ISMIE have an employee -- some kind of an employment liability line, also?

MR. GROSS: No, not anymore.

DIRECTOR MCRAITH: Not anymore. Did it at one time?

MR. ALLPHIN: Yes, we did at one time. We did write employment practices liability at one time.

DIRECTOR MCRAITH: Do you know when that was?

MR. ALLPHIN: That would have been in the late '90s, early '00s. We got out of that three or four years ago, something like that.

DIRECTOR MCRAITH: Okay. Was it before or after 2003, do you know?

MR. ALLPHIN: It was -- we got out of that line before 2003, yes.

DIRECTOR MCRAITH: Okay. Dr. Clementi, you -- and, again, these are just questions about your initial comments, and I'll have some more detailed questions on these topics later, but you made the comment that ISMIE's presence has been stedfast despite the turbulence. That raises a question for me. I thought that ISMIE established a moratorium on new policies in 2003 or '4.

DR. CLEMENTI: It did establish a moratorium. The reason was, there was such a large movement to the company, it became a financial risk to us. We went from something like 8,000 insureds up to over 13,000 insureds within a year, and as a result, to be able to handle that financially -- I mean, obviously, part of the reason our rating went down was because our surplus went down because we had to increase our reserves. So there was a whole bunch of movement that went on, you know, in that particular period, and a moratorium was put on because we didn't want to go to 15 or 18 or some large number. We didn't know how much this was going to go to. So the moratorium is on. It is on for anybody who is not coming with somebody who's already in association with us. So, for example, if a young person comes out in practice, we do accept them.

DIRECTOR MCRAITH: Well -- and I don't mean to interrupt because I'll ask you more questions about that later, but I'm just trying to understand when --

DR. CLEMENTI: Trying to build it for you.

DIRECTOR MCRAITH: Yeah. When you made the statement that your presence is stedfast through the

turbulence --

DR. CLEMENTI: Right.

DIRECTOR MCRAITH: -- and I thought maybe that was an overstatement. Would you agree?

DR. CLEMENTI: Well, I don't think it is because I think we've been there for the 13,000 insureds that we've had. We have a responsibility to those policyholders.

DIRECTOR MCRAITH: But in -- so your presence has remained consistent for your policyholders, but in terms of new applicants, maybe it has not been as consistent.

DR. CLEMENTI: Correct.

DIRECTOR MCRAITH: Okay.

DR. CLEMENTI: Might say that.

DIRECTOR MCRAITH: Okay. I think there was a statement that ISMIE assists its policyholders with IDPR proceedings.

MR. WASHBURN: Yes. Al?

DIRECTOR MCRAITH: Is that -- did I understand that correctly?

DR. CLEMENTI: Yes.

MR. ALLPHIN: There is, under the supplementary payments provision of the policy,

coverage for -- that's the reimbursement for defense costs for physicians who are called before IDPR, before the Department -- Division of Professional Regulation.

DIRECTOR MCRAITH: Right. Okay. And that would be in the event of some report of professional misconduct or --

MR. ALLPHIN: Whatever the source might be.

DIRECTOR MCRAITH: -- whatever the allegation?

MR.ALLPHIN: Yes, that's correct.

DIRECTOR MCRAITH: Okay. So it's a reimbursement of defense costs?

MR. ALLPHIN: That is correct.

DIRECTOR MCRAITH: Do you have a sense, Mr. Allphin, of what the impact of that is? How prevalent are those types of claims? Just in terms of numbers per year.

MR. ALLPHIN: Looking at those -- looking at those numbers that we -- we could get, I would say, between 25 and 50 requests a year, something like that.

MR. WASHBURN: We'll get back to you with specific numbers.

DIRECTOR MCRAITH: That would be great.

MR. WASHBURN: If you'd like.

DIRECTOR MCRAITH: Yeah. Did I understand that -- this statement: That in 2003, A.M. Best downgraded ISMIE two times because of the surplus declining; is that right?

MR. WASHBURN: That's right.

MR. GROSS: Yes.

DIRECTOR MCRAITH: Okay. The A.M. Best rating, is that, from the ISMIE prospective, a valid reason to change the rates?

MR. WASHBURN: It may not be a valid reason to change the rates, but it causes the company problems in that if you are less than an A-rated company, the brokers who you deal with have got to go to more work to get a sign-off from their policyholders that they will deal with you. In a hard market, it is not a major problem for an insurance company, depending -- for ISMIE itself because we have been here and we have been very steady for the policyholders, but as the market gets softer, the better risks have more problems dealing with us through a broker because of the lack of an A rating and A-rated paper.

DIRECTOR MCRAITH: But in a softer market, there are more options available for the prospective insured.

MR. WASHBURN: I understand, but ISMIE cannot afford to be in a place where all the good risks are leaving it because it's very difficult to deal with.

DIRECTOR MCRAITH: I understand. I mean, I think that's kind of the nature of the beast in a soft market, though, isn't it, Mr. Washburn? The competition?

MR. WASHBURN: You want to keep your rating up for two reasons. First of all, because it gives an indication of strength. The second reason you want to keep your rating up is because you want to make it easier for your policyholders to deal with you.

DIRECTOR MCRAITH: So I guess I -- just to get back to my -- to the question, the downgrade by A.M. Best, is that in and of itself a reason to increase rates?

MR. WASHBURN: It has not been a reason we used to increase rates, that's correct.

DIRECTOR MCRAITH: Okay. Mr. Gross, you

showed us a slide on -- that was captioned Return on Surplus?

MR. GROSS: Yes, sir.

DIRECTOR MCRAITH: And forgive me if you explained this, and I didn't understand it, but could you explain to me what you mean by return on surplus?

MR. GROSS: It's really just taking the amount of contribution, the policyholder surplus for the period, divided by the amount of surplus that we started with.

DIRECTOR MCRAITH: Okay. And am I correct that your characterization was that the return on surplus is below industry standard, and we've already talked, we don't know what the value of that comparison is yet, but it's lower than at least what some comparisons would suggest?

MR. GROSS: Yeah, we consider that return to be marginal. Probably just to be able to keep as close a pace as we can with loss trends.

DIRECTOR MCRAITH: Okay. I think you also showed us a slide on the net underwriting surplus; am I right?

MR. GROSS: I don't believe.

DIRECTOR MCRAITH: Net underwriting

leverage. I'm sorry. Forgive me.

MR. GROSS: Yes.

DIRECTOR MCRAITH: Could you define that for us?

MR. GROSS: Okay. It's premiums and reserves to surplus. It's taking the annual premium for the year -- and this is all on a net basis -- and the net reserves for losses and loss adjustment expenses that show up on the liability side. Taking the sum of those two, and dividing it by the amount of surplus we have. And in a period when surplus was higher, and prior to when we had to strengthen reserves, that leverage ratio was considerably lower, but never down to the level where, you know, the peer group is at.

DIRECTOR MCRAITH: Okay.

MR. WASHBURN: The reason it is used, Director, it gives you an indication of a mistake in either reserves or premium. How much that impacts -- how much that -- how big an effect that can have on your surplus.

DIRECTOR MCRAITH: Yes. If I understand the comparison -- I want to make sure I understand the comparison, Mr. Gross, and again, setting aside

questions about the accuracy of the comparison, at least on this chart, it shows -- it would suggest that ISMIE's net underwriting leverage might not be what you'd like it to be in --

MR. GROSS: Yes, that's correct.

DIRECTOR MCRAITH: -- in comparison to under -- in comparison to industry standards; right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: And then you showed a slide about the combined ratio, and this showed that the combined ratio for ISMIE Mutual was, I think, higher than the peer group and other P&C companies; is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: And am I correct that's not a favorable position to be in; is that right?

MR. GROSS: Yes, yes, and this particular ratio of 114 was higher than what we would have targeted when we set our premium rates.

DIRECTOR MCRAITH: And on a five-year average, it's even higher than -- at 126.2.

MR. GROSS: Right.

DIRECTOR MCRAITH: So that would suggest even less favorable --

MR. GROSS: Yes.

DIRECTOR MCRAITH: -- five-year average. Yeah. And the next slide that we looked at was the paid losses and ALAE by accident year.

MR. GROSS: Yes.

DIRECTOR MCRAITH: Could you explain to me again what this slide is telling us?

MR. GROSS: Okay. What we're showing here -- and taking the first column as an example. That's for the 1998 year. That's the coverage year for all losses that came in that apply to that year. This is showing each year, what percentage of the ultimate losses got paid each year one year out. And the purpose of that is to show how long it takes for the claims to get resolved for a coverage year, and during that period, we are also developing and that top line is moving up. Because at one point in time, what we -- for this '98 year, we probably had put up an amount of expected losses that was even less than what we've paid out already. So we've paid out more, and we've had to keep moving our ultimate loss projection up.

DIRECTOR MCRAITH: Is it -- I'm sorry. Go ahead.

MR. WASHBURN: I was just going to say, one of the things it shows is, how -- if you look at just your immediate past years, you do not have any certainty as to what those losses really were.

DIRECTOR MCRAITH: Right.

MR. WASHBURN: All of that's speculation, and so it takes you about four years out before you've even got 50 percent of the claims paid, which is really where you build your certainties, off paid claims.

DIRECTOR MCRAITH: And that's why medical malpractice is characterized as a kind of a long-tail line of business; right?

MR. WASHBURN: And a volatile line of business.

DIRECTOR MCRAITH: And volatile, right. But this is more -- this Power -- this slide is more just kind of a status report. It's not so much -- or a progress report. It's not so much a characterization of whether ISMIE is in good or bad --

MR. GROSS: This was just to demonstrate the long-term nature -- long-tail nature of the business.

DIRECTOR MCRAITH: Okay. There was a slide that's entitled Investment Yield Consideration.

MR. GROSS: Uh-huh.

DIRECTOR MCRAITH: Who prepared this slide?

MR. GROSS: I did.

DIRECTOR MCRAITH: You did. Okay. And what is -- in a sentence or two, what's the point of this slide?

MR. GROSS: Okay. The red line is the actual interest assumption that was provided to the actuaries in the determination of the present value factor to apply. And what we've traditionally tried to do is keep that -- we've measured it against what the overall portfolio for ISMIE is yielding year by year, and at the same time, what the five-year treasury is available at the time that the policy year starts so we can determine what we could reasonably expect to be available to invest new monies at. In the last two years, 2004 and 2005, we continued to use a 4 percent expected return, which is still in between, but what we did is we actually discounted it for the fact that because of the additional reinsurance programs that we've had to participate in, we are paying out 25 percent of our premium -- or -- yeah -- in the first year.
So we're only really being able to invest 75 percent

of our premium compared to how much we used to be able to investment, so --

DIRECTOR MCRAITH: So this slide is -- or effectively says that due to the various factors, ISMIE is not getting the investment yield that it might have received at one time; is that right?

MR. GROSS: Right. We're having to take that into consideration because we rely on that investment income to make up the difference, you know, between the premium we get and the amount we need to ultimately pay on the losses.

DIRECTOR MCRAITH: But the yield is not what it -- what ISMIE used to be able to rely upon, is that --

MR. GROSS: Right.

DIRECTOR MCRAITH: -- a fair statement of the point of this slide?

MR. GROSS: Yes.

DIRECTOR MCRAITH: Skipping ahead to the Credit Off Balance by Rating Year. Can you tell me again, the risk rewards -- well, I want to -- the loss -- this talks about how you would discount a rate for an individual physician; is that right?

MR. GROSS: What this really is, is our way

of being able to build into the pool of premium the amount we need to be able to apply the appropriate discounts to the appropriate policyholders because we need to have the money in there in order to be able to fairly distribute premium.

DIRECTOR MCRAITH: So, again, what this says is, as I read it, that there were, say, in 2003 -- and it's -- the way the graph is structured, it's a little deceptive, at least -- not deceptive deliberately, but it's a little misleading in the sense that the schedule rating is 18.9 percent, which is, in 2003, higher than it is in any other of those five years; right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: And that schedule rating would be a discount for a physician or surgeon based on certain schedule factors; right?

MR. GROSS: Yes. It's primarily in the economically integrated group area.

DIRECTOR MCRAITH: What do you mean -- oh, you mean where a physician or surgeon is part of a practice group --

MR. GROSS: Yes.

DIRECTOR MCRAITH: -- is that right? And

that's what you mean economically integrated?

MR. GROSS: Yes.

DIRECTOR MCRAITH: They work together?

MR. GROSS: Yes.

DIRECTOR MCRAITH: Okay. Then the loss-free percentage is again a discount for a physician or surgeon who is loss free --

MR. GROSS: Yes.

DIRECTOR MCRAITH: -- is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: The risk rewards, is that some kind of an additional discount that's given to a physician or surgeon if they participate in the risk management programs?

MR. GROSS: Yes. What we're trying to do is we're trying to move towards those types of credits for all physicians, and trying to encourage them to go out and participate in risk management programs and earn credits that way, and eventually, we expect that to be, along with the loss-free discount program, the predominant way to be able to get discounts.

DIRECTOR MCRAITH: Okay. It looks -- so am I right then that the -- as a percent, the discount

programs decreased in 2004 from 2003; is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: And then in 2005, they decreased again, although there appears to be, with the risk rewards discount, kind of a bump upwards.

MR. GROSS: Yes.

DIRECTOR MCRAITH: Am I correct in --

MR. GROSS: Yes.

DIRECTOR MCRAITH: -- reading that? The percentages, there's a -- looking at 2003, 28 percent. That's 28 percent of what?

MR. GROSS: Of the total premium that gets computed as the base premium.

DIRECTOR MCRAITH: Okay. But is that 28 percent of the individual physician's premium considering all the territory and class and other factors?

MR. GROSS: Yes.

DIRECTOR MCRAITH: And unique to that individual physician? So that if it's a -- what I'm asking, and I'm not doing it very well. You'll have to forgive me, but I'm trying to get a sense. Is that 20 percent -- 28 percent of what Dr. Washburn pays based on his history and his life, or is it 28

percent of a standard?

MR. GROSS: What it is, is -- and it's an inventory in time during the rating process where we take the total amount of premium that's manually computed versus the total amount that gets ultimately charged to the policyholders after underwriting has applied all of their criteria for schedule rating or identifying loss-free discounts and risk management discounts, and that difference is the -- it's the percentage of that difference that we have to build in so that when we go into this next rating cycle, we have enough in the manual rate still to be able to provide a similar amount of credit to the physicians based on the underwriting criteria. And underwriting is very aware of the amount of that money, you know, when they go to do their computations.

DIRECTOR MCRAITH: Speaking of underwriting, that's a division of ISMS; am I right?

MR. GROSS: MIS, yes.

DIRECTOR MCRAITH: MIS. Okay. Is that -- how many employees does ISMIS have?

MR. GROSS: Couple hundred?

MR. ALLPHIN: Claims is about 80, and I'm about 30, so that's close to --

DIRECTOR MCRAITH: Over a hundred?
MR. GROSS: I think between claims --
MR. ALLPHIN: ISMIS, between claims, underwriting, risk management, be about 150, 175, something like that.
DIRECTOR MCRAITH: Okay. And that's a separate legal entity than ISMIE Mutual, of course; right?
MR. WASHBURN: That's correct.
DIRECTOR MCRAITH: Is it funded by the policyholders of ISMIE Mutual?
MR. WASHBURN: It has a contract with ISMIE Mutual to do underwriting work. It was a -- when ISMIE was first formed --
DIRECTOR MCRAITH: No, hold on. I'm sorry, Mr. Washburn, to interrupt. I'm just trying to get a -- I understand there's a contract. So does ISMIE Mutual pay ISMIS for the services that ISMIS provides ISMIE Mutual?
MR. WASHBURN: It does. It does.
MR. MORSE: If I may, Director, Saul Morse, counsel. There is a contract on file with the Department, as required, under which ISMIS is a management company which manages certain of the

business affairs of ISMIE under contract. It gets compensated by ISMIE for its costs. There is no profit involved to ISMIS. Although it is incorporated as a for-profit company, wholly owned by ISMIE Mutual Insurance, it generates zero profit. Its only business, its only customer is ISMIE Mutual, and its direct costs are reimbursed by ISMIE, and those costs, of course, come from the premium dollars which are paid by the policyholders.

DIRECTOR MCRAITH: So all the salaries of the ISMIS employees are paid by ISMIE Mutual pursuant to the contract?

MR. MORSE: Ultimately, yes, the payment to them comes through ISMIE Mutual's payments to ISMIS for its services.

DIRECTOR MCRAITH: Uh-huh. We talked a little bit -- or I'm sorry. I think, Mr. Gross, you talked a little bit about the contingency margin, and looking at that slide, I see from 2000 to 2005 the contingency margin, which some carriers also call the profit load, is -- increases from 5 points to 9 points. Am I reading that correctly?

MR. GROSS: Yes.

DIRECTOR MCRAITH: And did I understand you

to say that the reason -- the principal reason for that increase is not an increase in contingencies, it's an increase in reinsurance costs; is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: So ISMIE purchases its reinsurance with this profit load.

MR. GROSS: With this contingency margin.

DIRECTOR MCRAITH: Contingency factor, right. The reinsurance is supposed to -- what's the purpose of the reinsurance?

MR. GROSS: It's to provide protection for changes in frequency and severity that are, you know, potentially out of the ordinary.

DIRECTOR MCRAITH: I'm sorry. Provides protection from increased frequency and severity that's potentially out of the ordinary, is that what you said?

MR. GROSS: Yeah.

DIRECTOR MCRAITH: Okay. And was that a philosophical shift by ISMIE to increase the amount of reinsurance it was purchasing or -- I mean, that's a big change. 4 percent increase to go in five years is a significant change, and I guess I have a question of what was driving that because -- and

excuse me, but isn't the contingency factor supposed to account for the potential increased -- the potentially unexpected contingency? I mean, isn't that what it's about?

MR. GROSS: The original increase -- well, we went from 5 percent in 2000 to 6 percent in 2001. Then we jumped up to 9 percent, but that was, as you can see, primarily to recognize substantial development that had been occurring in prior years, and the fact that we were feeling less comfortable about the assumptions, that as we go forward, we felt we needed to build some additional margin in there to cover what could happen going forward. And in 2003 is when we realized that we needed to go out and do something more in terms of reinsurance to be able to hedge further that margin, and we, as you can see, had to spend a substantial amount of that incremental contingency margin for that purpose.

DIRECTOR MCRAITH: Because -- and you'll forgive me, I am not -- I have not lived with the ISMIE world as long as you guys have, obviously. But isn't it -- doesn't reinsurance ultimately serve the same purpose that the contingency factor is supposed to serve?

MR. GROSS: To some degree it does.

DIRECTOR MCRAITH: And in this case, the increase of 4 percent in the profit load or the contingency factor was to reflect the increased costs of reinsurance?

MR. GROSS: Well, reinsurance also helps us try to bring our leverage for the company in line, too, because we, as you know, at our level of surplus, we cannot accommodate a substantial amount of premium or a substantial amount of reserves, and reinsurance will help us through -- ceding of premiums and ceding reserves helps us try to keep that more in line with our surplus.

DIRECTOR MCRAITH: What's the attachment point for the ISMIE reinsurance?

MR. GROSS: It's -- currently, we've got several programs in place. The most recent that we added was a 500/excess of 500 program. So that would mean that going forward, 500,000 is the attachment point for reinsurance. Whereas, in the past --

DIRECTOR MCRAITH: Is that for every claim, 500,000 or above?

MR. GROSS: It is now. Per incident.

DIRECTOR MCRAITH: Per incident.

MR. GROSS: Per loss.
DIRECTOR MCRAITH: Does that include expenses?
MR. GROSS: Yes.
DIRECTOR MCRAITH: So anything above $500,000, ISMIE is not -- it will be paid for by reinsurance; is that right?
MR. GROSS: Yeah, the indemnity would trigger the 500,000, but the expenses are prorated.
DIRECTOR MCRAITH: Sure. When was the reinsurance with the $500,000 attachment point purchased?
MR. GROSS: In October of 2003.
DIRECTOR MCRAITH: Okay. So since October of 2003, any loss in excess of $500,000 has been indemnified by reinsurance.
MR. GROSS: For losses that apply after the reinsurance went into place.
DIRECTOR MCRAITH: Right. Right. So, for example, the reinsurance that you buy in 2003 doesn't protect you from losses that -- for events that occurred in 2002 --
MR. GROSS: Right.
DIRECTOR MCRAITH: -- am I right? But going

forward then, as I look at this, 2003, 2004, and 2005, that --

MR. WASHBURN: It's an October purchase. So 2005 is not done yet.

DIRECTOR MCRAITH: Right.

MR. WASHBURN: We are currently looking at it.

DIRECTOR MCRAITH: But any loss based on an event in 2004, for example, from October 1, 2004 to October 1, 2005, that's in excess of $500,000 will be paid by reinsurance. Or will ISMIE be indemnified by reinsurance, or will the losses be paid by -- directly by reinsurance?

MR. GROSS: No, it will be indemnified.

DIRECTOR MCRAITH: Indemnified, okay.

MR. GROSS: We always pay the losses, first.

DIRECTOR MCRAITH: Yeah.

MR. WASHBURN: As was seen on the slide, Director, in 2002 there was a great deal of money put in the reserves for prior years' developments

DIRECTOR MCRAITH: Right. Right.

MR. WASHBURN: So there was a larger purchase of reinsurance because there was more uncertainty in terms of whether they really had a

good handle on what the future was going to be or not, and it led us to a larger buy of reinsurance from that point forward.

DIRECTOR MCRAITH: What are the exceptions or -- let me ask the question differently. Is there an exception to your reinsurance attachment? I mean, are there certain events that are not -- are certain losses not covered by reinsurance agreements?

MR. WASHBURN: Well, the underlying losses under $500,000, of course, are ours.

DIRECTOR MCRAITH: Right.

MR. WASHBURN: We buy clash cover as well, which is we have two policyholders in --

THE REPORTER: I'm sorry, I can't hear you.

MR. WASHBURN: Clash cover. I'm sorry. we have a clash cover over a million dollars for two policyholders where it happens to occur in the same event, and then we also buy cover for our policyholders who wish over $2 million, and that's actually a pass-through. The reinsurers determine the entire rate. We don't keep any of that money.

DIRECTOR MCRAITH: Okay.

MR. WASHBURN: I think that's the --

MR. GROSS: It's anything over a million

dollars.

MR. WASHBURN: Anything over a million dollars. I'm sorry. Anything over a million. We keep the first million on that.

DIRECTOR MCRAITH: ISMIE keeps the first million on any loss that's over a million dollars?

MR. WASHBURN: Well, and then we've also got a 500/excess of 500 cover for that piece of it as well.

DIRECTOR MCRAITH: Why don't you -- if you want to stand up and just answer.

MR. SKINNER: My name is Jim Skinner. I work for ISMIE, and I'm basically in charge of the reinsurance.

DIRECTOR MCRAITH: Okay. I'm sorry, Mr. Skinner, not that I would ever doubt your credibility, but did you -- were you sworn in?

MR. SKINNER: No, but I will.

DIRECTOR MCRAITH: Please.

(Mr. Skinner was duly sworn.)

DIRECTOR MCRAITH: Thanks. Go ahead.

MR. SKINNER: Our reinsurance program is structured on a lawsuit basis, and then we have a treaty that covers $2 million policies because we

issue -- I think this year it's going to be about 2400 $2 million per claim policies. One treaty covers the second million on a per claim basis, and that gets ceded off to reinsurers, hundred percent of that loss, and a hundred percent of what we charge the doctor for the second million dollars in coverage. That leaves a million dollar limit that is covered in a clash treaty where it's based on a lawsuit. So if we have -- we have a number of cases where there's more than one doctor that is sued in any one lawsuit.

DIRECTOR MCRAITH: Sure.

MR. SKINNER: So what we do is we run a clash cover that is four million/excess of one million per lawsuit at a million dollars of loss per doctor. So what that does is give us a million dollars retention on any lawsuit.

And then we have a 500/excess of 500 per lawsuit layer that sits right underneath that. So our retention is basically $500,000/excess of 500 per lawsuit. Now, that can get divvied up between three or -- if I have three doctors that are -- that you pay on a million dollars each, ISMIE will retain $500,000 of that loss. The rest will be ceded off to

reinsurers.

DIRECTOR MCRAITH: All right. Great. I think I understand. Has ISMIE ever had any problems with reinsurance collections?

MR. SKINNER: We have had some.

DIRECTOR MCRAITH: Any more than would be typical or expected?

MR. SKINNER: The problem you run into is, because this is such a long-tail business, you may be ten years out when you're trying to collect against a reinsurer that you wrote -- that wrote your policy -- who reinsured you back ten years earlier. Sometimes they do have problems. We --

DIRECTOR MCRAITH: Mr. Greenberg might be able to talk about that.

MR. SKINNER: We -- on non-admitted carriers, we require letters of credit, and those are posted for security. Admitted carriers in Illinois, we don't require letters of credit. We watch their A.M. Best rating, we watch their financial security quite closely, along with our brokers. We get regular reports from brokers on reinsurers.

DIRECTOR MCRAITH: At one time did ISMIE have contracts with reinsurers that were not well

regarded?

MR. SKINNER: At one time we had contracts with reinsurers that were not rated by A.M. Best simply because they were European -- mostly European carriers at the time.

DIRECTOR MCRAITH: So does that mean they were not admitted?

MR. SKINNER: They were not admitted, yes. Yes, and they were posting LOCs.

DIRECTOR MCRAITH: Okay.

MR. SKINNER: And back in the -- before we got our A.M. Best rating, we were an A.M. Best rated NA-6, which meant that we were reinsured with reinsurers that were not A.M. Best rated. Reason they weren't A.M. Best rated is A.M. Best wasn't rating European reinsurers.

DIRECTOR MCRAITH: Okay. Am I correct that a $500,000 attachment point is very reasonable, if not fairly low, for a malpractice -- medical malpractice?

MR. SKINNER: It's a working layer. What we would call in the industry a working layer.

DIRECTOR MCRAITH: What does that mean, Mr. Skinner?

MR. SKINNER: It means it's going to get hit quite a bit.

DIRECTOR MCRAITH: Right.

MR. SKINNER: You're going to have losses ceded to it.

DIRECTOR MCRAITH: Do you have a sense of whether that's low for the industry?

MR. SKINNER: I couldn't tell you what other companies do, and I think it goes upon what their need is. There are companies that don't -- probably don't have as much clash exposure that we do, and they don't get as many doctors sued in one lawsuit. They may go to a different type of reinsurance structure. We do quite a bit of modeling on ours to see how it reacts if you have increased frequency, increased severity. We kind of do a lot of modeling on it, and, say, okay, how does this layer react if this happens or if this happens. So we kind of try and design it to us. I could not tell you what other companies do. Just as a guess, I've heard of companies going down farther than that to like 250. We felt that the 500 level was good for us.

DIRECTOR MCRAITH: Okay. Now, the 500 level, again, that was purchased for the first time

in 2003?

MR. SKINNER: Yes, and it started October 1, 2003.

DIRECTOR MCRAITH: Now, just to summarize to make sure that I understand this correctly, there's a $500,000 -- ISMIE would suffer at most a $500,000 loss on an individual claim. That's indemnity and expense; right?

MR. SKINNER: It's indemnity pro rata expense. So we would have $500,000 indemnity, and then our share of the expenses added onto that $500,000 we would keep.

DIRECTOR MCRAITH: Okay.

MR. SKINNER: The treaties are indemnity with losses pro rata is what they call it in the industry, and that just means that if you've got all your expenses here, in relation to whatever you had to pay to indemnity, you take that much of the expense.

DIRECTOR MCRAITH: Understood. Okay. So if we exclude expenses, though, from an indemnity perspective, ISMIE, on an individual lawsuit, it's maximum exposure is $500,000?

MR. SKINNER: Correct.

DIRECTOR MCRAITH: Now, if there's more than one ISMIE-insured doctor in a lawsuit, the maximum exposure is a million dollars?

MR. SKINNER: No, that still is $500,000.

DIRECTOR MCRAITH: It's still 500 even if it's for the whole group of defendants?

MR. SKINNER: Yes, because that is an event cover.

DIRECTOR MCRAITH: I see.

MR. SKINNER: See, what would happen is that at the --

DIRECTOR MCRAITH: I think you've answered my question. Thank you. It's about five to 11:00. We've been going almost an hour and a half or a little more than that. Why don't we take a ten-minute break, and we'll reconvene at five after 11:00. Thank you.

(Short break.)

DIRECTOR MCRAITH: All right. If we could get started again. We were finishing up our discussion on the reinsurance contracts before we took a break, and could we put the slide up there again? Well, let me ask this: Does that 9 percent cover the total -- I think it was 9 -- it was

actually like 7.4 percent, as I recall. Does that cover the total cost of the reinsurance contracts for ISMIE?

MR. GROSS: 7.6 of that.

DIRECTOR MCRAITH: 7.6.

MR. GROSS: What it does, it covers what we think the cost will be based on expected losses for the year.

MR. WASHBURN: The 5 -- actual 5 is a swing rated program, you understand? So if losses go up, we pay more.

DIRECTOR MCRAITH: Sure. But that --

MR. GROSS: It's not the total amount of premium that we're going to pay. It's the --

DIRECTOR MCRAITH: Well, then, what is it? If it's not total premium you're going to pay, what is it?

MR. GROSS: It's the reinsurer's margin. You know, the amount that they expect that they're going to be able to make on that program.

DIRECTOR MCRAITH: Okay. Are there any other costs of reinsurance that are reflected in the premiums or the rates?

MR. GROSS: No, that's all covered in

this -- it's all coming out of the contingency margin.

DIRECTOR MCRAITH: It's all coming out of the profit load or the contingency factor.

MR. GROSS: Yes, and all that's left is 1.4 over and above that.

DIRECTOR MCRAITH: Okay. But where --

MR. WASHBURN: But the actual funds that the reinsurers charge us, they -- we send them a proportional amount of our premium that is larger than that part of the premium --

MR. GROSS: Yes.

MR. WASHBURN: -- for what they anticipate the losses will be. In other words, there is a charge for that, and then in that charge -- in the charge that we send them is a margin for their costs and their -- and their -- their actual margin. What we reflect -- I think what Bud reflects, and tell me if I'm not right, Bud -- in the contingency margin is, aside from the loss costs, what we think the reinsurers are collecting; is that a fair statement?

MR. GROSS: Yes.

MR. WASHBURN: So the loss costs -- the actual cost of reinsurance is larger than 7.6 percent

of our premium.

DIRECTOR MCRAITH: Okay.

MR. GROSS: Basically --

DIRECTOR MCRAITH: What is it? I mean, if it's not 7.6, then what is it?

MR. WASHBURN: The difference between net --

DIRECTOR MCRAITH: Mr. Skinner -- I'm sorry. Did you want to add something?

MR. SKINNER: The premium that we see to reinsurers on the four million/excess of one million is 15.1 percent of our premium. What that represents is the difference between the losses that we expect to be paid back to us by reinsurers and that 15.1 percent. So when the reinsurers price a treaty, they'll say, okay, we expect the losses to be ceded to us to be a certain amount. Then they'll add a margin on top of that in case they're wrong. And that's what is ceded out. What comes up -- what is -- what Bud's represented there as the reinsurance cost is basically that margin. On the million/excess of a million treaty, that is all -- that's not included here, and that's ceded out. A hundred percent of the losses --

DIRECTOR MCRAITH: Right. Understand.

Okay.

MR. WASHBURN: Why don't we do this: Why don't we give you a page that shows the actual costs over the last several years of the reinsurance.

DIRECTOR MCRAITH: That would be great if you want to submit that. Yeah. Mr. Skinner, do you work for ISMIS?

MR. SKINNER: Yes.

DIRECTOR MCRAITH: Okay. One final -- well, two final questions for the reinsurance. Do the reinsurance contracts cover economic and noneconomic damages?

MR. SKINNER: Yes, they cover all damages that we have to pay.

DIRECTOR MCRAITH: Okay. And do the reinsurance contracts actually transfer risk, or is it only a financing mechanism?

MR. SKINNER: It's a transfer of risk.

DIRECTOR MCRAITH: Okay.

MR. SKINNER: They would tell you too much.

DIRECTOR MCRAITH: Looking at the slide, and I apologize if I'm jumping back and forth a little bit, but the slide titled Return on Surplus, Mr. Gross. You commented that the return on surplus

trails the industry. I mean, without revisiting the value of the comparison, I'd like to get a sense from you or get an explanation from you as to why -- why is there a return on surplus question for ISMIE?

MR. GROSS: A question. You mean --

DIRECTOR MCRAITH: You're saying that it trails industry. Why do you think it trails industry?

MR. GROSS: Because we don't build a profit factor into our premium rates. Whereas, a company that -- you know, certainly in the U.S. P&C industry, probably half of those companies are -- probably more than half are stock companies. You know, they may have an expectation of a return that they have to have in their surplus. The peer group of companies, some of them may be stock companies. You know, they may have an expectation of a higher return. What we've always tried to do is make that return only what we felt we needed in order to keep surplus moving on the track necessary to cover our exposure.

DIRECTOR MCRAITH: Is the return on surplus a reflection of rate inadequacy?

MR. GROSS: If we can accomplish the 4 percent return, we're feeling that we are doing the

best service to our policyholders in terms of being able to keep surplus at a level necessary to keep going as we are. But it's a small margin, and as you can see, you know, without any real contingency margin built in there, it's very difficult to assure that we're going to accomplish that.

DIRECTOR MCRAITH: Is it -- is the return -- is ISMIE's return on surplus a reflection of either -- inadequate investment yield?

MR. GROSS: No, because we all -- we have a commitment -- well, not a commitment. We have an investment committee that reviews our guidelines and objectives on an annual basis, and we do determine what we feel is the amount of investment income that we need, and we have targets.

DIRECTOR MCRAITH: But is the return -- does the return on surplus trail the industry standard because ISMIE has different investment standards, and perhaps a lower investment yield than the -- those companies that might be in this comparison?

MR. GROSS: The return would not because if we targeted a higher return, we would -- well, we wouldn't -- we target the return that we feel that we can make.

DIRECTOR MCRAITH: Uh-huh. And --

MR. GROSS: We have a very conservative portfolio, high quality. We try to minimize the amount of risk we have in that portfolio.

DIRECTOR MCRAITH: Right. Right. And we'll talk at some length about that later on. I'm just trying to understand why the return on surplus trails -- trails industry, to quote, I think, what you said, and just want to talk with you about a couple of these factors. For example, do ISMIE's administrative expenses impact the return on surplus?

MR. GROSS: They have not affected it unfavorably because we've priced adequately for it in our premium rates.

DIRECTOR MCRAITH: And how about the underwriting process itself, has that impacted return on surplus?

MR. GROSS: The process of assessing risks and --

DIRECTOR MCRAITH: Uh-huh.

MR. GROSS: I think -- I think it's favorably impacted it.

DIRECTOR MCRAITH: I believe -- I'm sorry, I don't remember right now who made the statement that

the group rating has gone down over time because of the risk rewards programs; is that right? Did I hear that correctly?

MR. WASHBURN: We talked about the fact that this year, with the risk rewards, we are not looking at as much group credits, yes. I think Mr. Gross said that.

DIRECTOR MCRAITH: Are the group credits different from the -- is it a 21 percent increase that corporations and partnerships receive this year in their rates?

MR. GROSS: That would be a separate factor. The amount of corporate charge having increased would be part of the rating -- the manual rating process as it applies to corporations.

(Cell phone interruption.)

DIRECTOR MCRAITH: This is not a wedding I don't think, is it? I've heard that song before. Explain to me, when you say group rating then, what are you referring to? What is the -- when you say group rating went down over time, what do you mean? Who is the group? What is the group?

MR. WASHBURN: The schedule credits for clinics or associations of doctors that have

economically integrated together, groups of doctors.

DIRECTOR MCRAITH: Okay. And that's no different from the corporations or the partnerships that are insured by ISMIE; right?

MR. WASHBURN: But there's a separate corporate policy for a corporation.

DIRECTOR MCRAITH: Separate from a group?

MR. ALLPHIN: There is a -- there's a separate corporate policy. We write a separate corporate policy for the entity, separate and distinct from the doctors. We will write individual physicians on an individual policy. We will write a corporation on an individual policy, and we'll put the two together in one policy. In other words, we'll put the entity and the doctors together under one policy. Okay. When -- so the entity rate -- the charge that we make for entities is 25 percent of the underlying physician premiums; that is, the physician members of that group, capped at a maximum of the average of the five highest doctors in that group. With respect to -- does that answer your question before I go on?

DIRECTOR MCRAITH: It does.

MR. ALLPHIN: Okay.

DIRECTOR MCRAITH: Yeah. Thank you. Am I correct, though, that the premium for -- premium rate for corporations and partnerships this year went up in excess of 20 percent? Am I right about that?

MR. ALLPHIN: Yes. Yes, Director, the rate went up from 21 percent to 25 percent of the underlying physician premiums, yes.

DIRECTOR MCRAITH: Okay. Thank you, Mr. Allphin. Again, just trying to clean up some open questions. Mr. Morse, if I could put you on the spot again. You said that ISMIS, I-S-M-I-S, is a -- legally, a for-profit company, but it is a non -- it's nonprofit operationally; is that right?

MR. MORSE: It does not generate any profit. Its contract with ISMIE Mutual is based solely on a reimbursement of its direct costs.

DIRECTOR MCRAITH: Okay. How do you define profit when you say that?

MR. MORSE: I would define profit as it not billing its customer one penny beyond its direct out-of-pocket expenses for providing service.

DIRECTOR MCRAITH: And direct costs or direct expenses then are the -- would include labor, rent, benefits, everything for the 150, 175 people?

MR. MORSE: Right. Right.

DIRECTOR MCRAITH: Okay. Is there a cap on what ISMIS can charge ISMIE by contract?

MR. MORSE: Not at the current time under the current contract.

DIRECTOR MCRAITH: How are those direct costs determined then? Or who -- let me -- I'm sorry. Let me back up. Who has the authority to determine what the direct costs will be?

MR. MORSE: ISMIS has a board of six physicians elected by the shareholder, all of whom are policyholders of ISMIE Mutual. As with any board of any corporation, they oversee the operations. As a wholly owned subsidiary, they do listen intently to the direction of the board of ISMIE Mutual, all physician policyholders, if they were to say we would like this service provided, we'd like you to expand this service, or we'd like you to contract this service. So there is that oversight, and there is a shared, if you will, staff. There has been for 25 years -- 26 years now between the two that are attentive to both boards.

DIRECTOR MCRAITH: Does ISMIS have an audit committee? Does its board of directors have an audit

committee or any kind of a compliance committee?

MR. GROSS: It has a finance committee.

DIRECTOR MCRAITH: A finance committee.

MR. MORSE: Finance committee. It is audited by independent auditors. It does not have a separate audit committee.

DIRECTOR MCRAITH: And, Dr. Clementi, am I right that you are the president of the ISMI -- chairman of the ISMIS board?

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: Were you ever on the board for ISMIE?

DR. CLEMENTI: For a short period I was on the board of ISMIE, but not concurrently. At the time I was on the ISMIE board, I was off of Services board.

DIRECTOR MCRAITH: Okay.

DR. CLEMENTI: And that occurred on two occasions.

DIRECTOR MCRAITH: Okay. Briefly, there was the discussion about the territories, and we'll discuss this in greater length later, but I guess just a simple question that I have is, you know, I understand that the territory designation has evolved

to be fair and accurate. I think that was the statement that was made.

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: How is it that Kane County and DuPage County, which I think are similar demographically --

DR. CLEMENTI: Almost.

DIRECTOR MCRAITH: -- in different territories?

DR. CLEMENTI: Well, they're different because what has happened is, because of those borders, there are different doctors -- there are some doctors who practice in both, but for the most part, there are different hospitals, and each loss is identified within that particular county. So we get information from our actuaries as to what the losses are within that particular county. It looks similar. Just like you could say Kane and DuPage are sitting right next to each other, but Kane and DuPage are different, and Kane and Will and all the other counties that they may border on -- I mean, each of the counties that they border on have differences in what their losses are, and we try to identify doctors who practice primarily within those particular

borders, and what their losses are. We do the best we can. Obviously, there are some people that practice on both sides, and they may have a loss on one side and so forth.

DIRECTOR MCRAITH: I'm sorry to interrupt, but -- so the -- if a county is in a territory different from another county, it is because there is a loss experience that's different from the other county.

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: So you're saying that Kane County, for example, has a different loss experience than DuPage County.

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: I wanted to ask one question, and I'll tie this into other questions later, but the -- you talked about obstetricians.

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: And I think we've all heard the discussion about how obstetricians can be kind of hard to come by these days.

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: And I, in fact, understand that that is not uncommon, nationally

there is a problem with that. Would you agree with that or --

DR. CLEMENTI: Well, as far as the distribution, the American Medical Association talks about distribution of physicians. For the most part, there is more commonly a concentration toward the larger cities, but in general, there are certain areas that are underserved in certain specialties.

DIRECTOR MCRAITH: Throughout the country.

DR. CLEMENTI: Throughout the country.

DIRECTOR MCRAITH: Yeah. And would you say -- I know that ISMIE is not a healthcare insurer, but do you know what the relative compensation to an obstetrician is between today and, say, 15 years ago?

DR. CLEMENTI: I would have no idea. I mean that's data possibly the American Medical Association could supply you with, or we could get it for you if you'd like. In other words, what the average obstetrician in the United States --

DIRECTOR MCRAITH: What an obstetrician has been paid historically per -- on a per-birth basis. I'd be interested in -- if you can get me some information on that, I'd be -- it's not directly relevant to our inquiry, but it's my understanding

that obstetricians were paid about $3,000 in 1990, and they're now paid about $1900 per birth for deliveries.

DR. CLEMENTI: That's possible. I don't have that data, but I will try to find that for you.

DIRECTOR MCRAITH: That would be great. Thank you.

DR. CLEMENTI: Sure.

DIRECTOR MCRAITH: Mr. Washburn, I think you made the statement that in the last soft market competitors -- competitors took the low-risk specialties from ISMIE, or attempted to. Did I understand that correctly?

MR. WASHBURN: Yes.

DIRECTOR MCRAITH: When was the last soft market?

MR. WASHBURN: The last soft market in this business was in '99 and 2000, 2001.

DIRECTOR MCRAITH: And a soft market, am I correct, is a market where there is sufficient capital in the marketplace, there's competition --

MR. WASHBURN: Prices decline.

DIRECTOR MCRAITH: -- prices decline, prospective insureds have different options.

MR. WASHBURN: That's correct.
DIRECTOR MCRAITH: Right.
MR. WASHBURN: They have increased options.
DIRECTOR MCRAITH: Have increased options, yes. Thanks. What impact -- did ISMIE lose insureds during the last soft market in terms of pure numbers of insureds?
MR. WASHBURN: Yes.
DIRECTOR MCRAITH: It did. Do you know by how many?
DR. CLEMENTI: About 2,000.
MR. WASHBURN: We have the numbers of insureds by year that we'll get to you. I don't have them at my fingertips.
DIRECTOR MCRAITH: Okay. And was the loss -- do you know, Dr. Clementi, was that loss of insureds due to just attrition in the marketplace, or is it because the insureds went to another insurer?
DR. CLEMENTI: There were a large number of insurance companies that came in, and tried to identify some group that they could lowball, they could underrate, and as a result, those particular specialties were given a better rate than we had calculated. We had calculated on the basis of what

our losses -- what we knew our losses were. So in that process, they were trying to develop a book of business, you know, two, 300 physicians to be able to write within a particular area so that they could spread their risk out and so forth, and in the process, by giving a lower rate, they were able to do that. And I'm guessing the number, but I would say close to 2,000 insureds. We went from maybe 9,000 down to about seven, and then since that time -- and then, of course, with the hard market developing, we went all the way up to 13,000.

DIRECTOR MCRAITH: What impact did the soft market have on your rates? When I say your rates, I mean the ISMIE rates.

DR. CLEMENTI: The whole process of our rate setting was what are the losses. I mean, if we have most the general surgeons practicing in the State of Illinois with us, we know what the losses for the general surgeons are in Illinois, and we know what their rates should be. When somebody comes up and gives a lower rate than us, we're sort of standing there with this higher rate, and we can't really lower it because if we do, then the people that are there are not -- they're not paying their own load.

So we ended up where we had, in certain specialties in certain areas, higher rates than other people did.

DIRECTOR MCRAITH: So ISMIE lost insureds because it did not lower rates during the last soft market.

DR. CLEMENTI: We did not -- we did not lower the rates because we -- they were not appropriate to lower. Yes, we did not.

DIRECTOR MCRAITH: Right. Right. What impact did that have on ISMIE's surplus position?

DR. CLEMENTI: I don't know.

DIRECTOR MCRAITH: If any.

MR. GROSS: Nothing initially because we were pricing, you know, what we felt was appropriate. But in retrospect, I guess you could say, you know, that some of the losses developed beyond the pricing assumptions, and that would have an adverse impact on surplus after the fact.

DIRECTOR MCRAITH: I guess what I'm trying to understand is, a soft market might not be the best thing for ISMIE, but there are people who would say that the more competition and the more capital in the marketplace, the better for the prospective insureds because the rates are going to be better.

DR. CLEMENTI: As long as it isn't predatory. If it's predatory, and it goes in with the idea that we will give a lower rate to any particular individual so that we will get them on our books, and then maybe increase them at a later time, that -- what that does is, it makes it look like the rates should be lower, but we know from experience what the losses are for the specialty, and because of the large number of insureds that we had in Illinois at that time, we knew what was going to be the losses, and it proved right. We had these terrible losses, and the other company said we're leaving.

DIRECTOR MCRAITH: All right. Well, what I don't understand then is, if -- the soft market did not cause you to decrease your rates; is that right?

DR. CLEMENTI: We did not.

DIRECTOR MCRAITH: So if there were a rate change, it had nothing to do with competition; is that right? If ISMIE had a rate change at that time, during the last soft market, it had nothing do with competition.

DR. CLEMENTI: I don't think so. I mean, there would be no reason to do it. It was -- our attempt was to rate appropriately, and we were

usually rated higher in certain specific areas of specialties.

DIRECTOR MCRAITH: All right. But then when the market hardened, and there was less competition, ISMIE increased its rates 35 percent; is that --

DR. CLEMENTI: Because of what happened in the -- in that period of time as far as what the losses were. The losses were terrible in those two or three years, and it became very evident that everybody, including us, may have been at a lower rate than we should have, so -- but the point is, what we're trying to do is to rate appropriately with whatever data we have in the past, and there were a couple years that losses were coming in very high.

DIRECTOR MCRAITH: Again, I just want to make sure I'm understanding what you're saying. You're saying that the 35 percent rate increase in 2003 was the result of significant losses -- unexpectedly significant losses the prior years?

DR. CLEMENTI: No, it was because of what the trend was at that time in the way of increased losses. Again, the actuarial process is to try to look forward to what the predicted losses are. We weren't making up for past years. We were -- the

increase was because of what the losses were seen to be predicted for the future because of what we saw happening in the size of awards and other factors.

DIRECTOR MCRAITH: The -- yes.

MR. WASHBURN: I think, Director, what you see, though, with the loss ratio was that in prior years there had been rates that were not adequate for the losses that came forward. Not because of the soft market, but it was because the act -- we just missed the rates that were needed.

DIRECTOR MCRAITH: Right. Right. So the rates in the prior years were lower than they should have been based on what your --

MR. WASHBURN: What our experience --

DIRECTOR MCRAITH: -- what our experience shows us now.

MR. WASHBURN: -- ultimate experience has proved out to be right.

DIRECTOR MCRAITH: And as a result of that, there was a -- that triggered a financial reaction at ISMIE that resulted in a 35 percent increase; is that right?

MR. WASHBURN: If you -- because of the long-term nature of this business, if you miss your

rate one year, and you're looking at the last year and so forth, there's sometimes a buildup of problems over time that you have missed it by such a degree that you have to have a large increase to make it, to get your rates to where they should be for the next -- for that particular year, that's correct.

DIRECTOR MCRAITH: And, Dr. Clementi, I understand you've been involved with ISMIE for three decades now. It is officially 30 years; am I right?

DR. CLEMENTI: That's right.

DIRECTOR MCRAITH: How many -- are you able to recall how many soft markets and hard markets you've seen in that 30 years?

DR. CLEMENTI: I can't. I will say that this last one was probably the most significant. I don't remember any time when we had that many other insureds in the market, and their reason for coming in, I have no idea. Whether they were looking for investment someplace else, I have no idea, but it just seems as though at that particular time there was just a large number, and probably the largest number that I've ever seen at one particular time. We've had fluctuations, but not to that extent.

DIRECTOR MCRAITH: So you've seen other soft

markets before the soft market in '99 to 2001; is that right?

DR. CLEMENTI: Well, to say that I've seen them, I can't really tell you offhand. If you were going to ask me what years, I can't tell you. Were there times when there was more availability soft market? Yes, there were times. To the extent of this last one? No. Was there any time when there were more insureds than there are today? Yes. I mean, there were times.

DIRECTOR MCRAITH: Do you mean insurers?

DR. CLEMENTI: Or insurers. I'm sorry. I meant insurers. So, yes, there were.

DIRECTOR MCRAITH: And you've seen in addition -- in conjunction, I suppose, with the soft markets, you've also seen hard markets throughout 30 years; is that fair to say?

DR. CLEMENTI: Right, but never, again, to the extent that we're in now where we have four or five companies only that are writing in the State of Illinois, and almost all of them are in the same situation that we are. They're very selective in who they insure. They have a moratorium or -- they don't call it a moratorium, but they have something else in

place that restricts who they will and won't insure.

DIRECTOR MCRAITH: So do you know -- I don't want to digress too far, but do you know, of those four or five companies you're referring to, how many of them are mutual companies?

DR. CLEMENTI: I don't know how many are mutual.

DIRECTOR MCRAITH: Okay.

MR. WASHBURN: I think we'll get back -- we'll get back to you.

DIRECTOR MCRAITH: I think I know the answer. I mean, I think it's -- I don't think any are.

MR. WASHBURN: Yeah, we have the list. It may not be.

DIRECTOR MCRAITH: Yeah. I guess what I'm trying to get at, Dr. Clementi, again, you've been on the -- involved with ISMIE in some form or fashion for 30 years.

DR. CLEMENTI: Right.

DIRECTOR MCRAITH: And has it been your observation that the medical malpractice market is a cyclical market; that it will cycle from a soft market to a hard market and around again.

DR. CLEMENTI: Yeah, there is some cyclic nature to it, and as our rates have expressed, there's been some increases in rates, some very stable years where we increased very little, if anything. So, yes, there have been harder markets and softer ones, but the point is, none to the extent that what we're dealing with at the present time.

DIRECTOR MCRAITH: So would you characterize the market today as a hard market?

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: And you're saying that in your 30 years you have not seen -- in the cycle of soft and hard markets, you've not seen a market as hard as the one we're experiencing now; is that fair to say?

DR. CLEMENTI: I would guess that. That would be my opinion.

DIRECTOR MCRAITH: Okay. You're going to let me know the total number of insureds that ISMIE has --

MR. WASHBURN: By year.

DIRECTOR MCRAITH: -- by year?

MR. WASHBURN: Yes, we'll get you the last ten years.

DIRECTOR MCRAITH: Can you -- do you have an estimated percentage of licensed doctors that are insured by ISMIE, Illinois licensed doctors?

MR. WASHBURN: You want our estimate of it?

DIRECTOR MCRAITH: Well, unless you can give me an exact percentage.

DR. CLEMENTI: You mean a percentage of those in Illinois who are --

DIRECTOR MCRAITH: Who are licensed and practicing in Illinois. I think I just said licensed. I mean licensed and practicing.

DR. CLEMENTI: We can get that number for you.

DIRECTOR MCRAITH: Okay. I've seen one compilation of earned written premium for all the med mal writers in Illinois based on 2003 annual reports, and that compilation says that -- or shows that ISMIE collected, in 2003, 67 percent of the earned written premium for physicians practicing in Illinois. Do you have any response to that, whether that's accurate or not?

DR. CLEMENTI: I can't tell you.

MR. GROSS: Well, I believe it's in the 60 percent range, but that doesn't include all

physicians that are practicing. That's just -- because there's a lot of physicians that are employed by hospitals, but wouldn't be in those numbers, necessarily, or there's risk retention groups or captives that, you know, where physicians are insured, but they would not be showing up in that comparison.

DIRECTOR MCRAITH: Yeah, I understand, Mr. Gross. When I'm talking about 60 -- again, it's -- I didn't do this independently, so I don't have personal knowledge. I didn't run the numbers myself, but I saw a report and analysis that said that of the earned written premium collected from med mal carriers in Illinois in 2003, ISMIE received 67 percent of that. Is that --

MR. WASHBURN: I think there's an NAIC report that comes out that looks at -- there's a page for showing the state that you wrote in and the amount of premium, and I think there's a report that comes out dealing with who is a medical malpractice carrier, and their -- you know, you can do a compilation off of that.

DIRECTOR MCRAITH: Yeah. This was based on the annual reports of all known carriers in the

state, yeah.

MR. WASHBURN: That would, again, not include anyone who is a risk retention group or --

DIRECTOR MCRAITH: Sure, but people who -- but what it includes are people who are insured by conventional insurance.

MR. WASHBURN: Right.

DIRECTOR MCRAITH: In Illinois.

MR. WASHBURN: Right.

MR. MORSE: But, Director, if I may, just for the record on that, as an example, approximately -- I believe it's 26 percent of the healthcare provided in Springfield by physicians are provided through a group which is self-insured, which would not show up anywhere.

DIRECTOR MCRAITH: That's exactly right. I'm not debating or disputing. I think it's something like 70 percent of hospitals are self-insured. Am I --

MR. MORSE: Just so it's clear that --

DIRECTOR MCRAITH: I think it's approximately that number.

MR. MORSE: -- there's a substantial number of physicians practicing in Illinois who would not

show up in that number either because they are employed by a hospital, or they're in a self-insured -- like a faculty practice plan at a medical school and the like. And just as the number you asked earlier, the number of licensed physicians in Illinois, the fact that they have a license which can be derived from another division of your own Department, does not mean they're practicing in Illinois. A substantial number of them maintain licenses in multiple states, or they're in the military, and I don't know that we can get you a number of how many are actually practicing in Illinois.

DIRECTOR MCRAITH: No, I wouldn't expect you to. I guess I'm just most interested in terms of numbers of insureds that ISMIE has, but that really is a separate issue. As you know, we don't regulate the self-insureds --

MR. MORSE: Right.

DIRECTOR MCRAITH: -- in that way. We know of the insureds in -- who are insureds by conventional malpractice insurance, that at least based on 2003 annual reports, it looks like 67 percent of the premium collected went to ISMIE

anyway. So you're right, we -- that's a separate issue, and I appreciate that clarification.

Our plan right now is to go until 12:30, and we'll take then a half an hour, maybe 45 minutes, to get something to eat, and then we'll resume one o'clock or 1:15, and we can determine at that point how much progress we've made at 12:30, and whether we should take a half an hour or 45 minutes, but just for anybody interested in planning ahead.

ISMIE submitted a rate filing for 2005; is that right?

MR. WASHBURN: That is correct.

DIRECTOR MCRAITH: Did that rate filing have any calculation of change in rate for 2005 as opposed to 2004?

MR. WASHBURN: I'm not quite sure --

DIRECTOR MCRAITH: An overall change in -- let me back up. Let me back up. Did ISMIE submit to the Division of Insurance a rate filing that reflected a minus .2 change in premium collected for 2005?

MR. WASHBURN: Yes.

DIRECTOR MCRAITH: Is that fair to say?

MR. WASHBURN: I believe that's the case; is

that right? We can look at the filing, but I believe that is the correct number.

DIRECTOR MCRAITH: I could direct you to a page --

MR. WASHBURN: Minus .17, but yes.

DIRECTOR MCRAITH: Okay. Looking at the summary sheet which is Substitute Form (RF-3), and I think you guys have binders at your tables. This would be the ISMIE Mutual rate filing, and it's been marked as Exhibit 1.

MR. WASHBURN: Right.

DIRECTOR MCRAITH: And do you see -- do you have in front of you --

MR. WASHBURN: Yes, we do.

DIRECTOR MCRAITH: -- Substitute Form (RF-3)?

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: If I'm reading this correctly, it shows a percentage change of minus .2 percent; is that right?

MR. WASHBURN: That is correct.

DIRECTOR MCRAITH: That's minus .2 percent of what?

MR. WASHBURN: Of our current rate.

DIRECTOR MCRAITH: Meaning -- okay. Let me ask the question differently. Is that a change in annual premium volume? Is that a minus .2 percent change in annual premium volume, or is that a change in actual rate paid?

MR. GROSS: That's the annual premium volume. Change in annual premium volume.

DIRECTOR MCRAITH: Change in annual premium volume, and the annual premium volume is gross premiums collected from all insureds for the coming year; is that right? And that's based on assuming the world for -- ISMIE world doesn't change one iota from 2004 to 2005; is that right?

MR. GROSS: That's taking the inventory of policyholders at one point in time before the rate, and then showing what they would be after the effect of the rate changes.

MR. WASHBURN: You are correct.

MR. GROSS: The overall premiums.

DIRECTOR MCRAITH: Right. So in other words, you take 2004, the ISMIE world of 2004, you transfer that to 2005 without any change, and you're saying on the rates proposed in this filing, that annual premium volume will decline by .2 percent.

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: Okay. That's not a -- the doctors themselves don't pay -- their individual rates are not .2 percent less, are they?

MR. WASHBURN: Overall.

MR. GROSS: This is an aggregate.

MR. WASHBURN: Overall, they will have paid 2 percent less.

DIRECTOR MCRAITH: They will have paid --

MR. WASHBURN: But there will be changes within those rates, so some will pay more and some will pay less.

DIRECTOR MCRAITH: But that .2 percent is really not a percentage change in rate paid, it's a percentage change in premiums collected; am I right?

MR. WASHBURN: Yes.

DIRECTOR MCRAITH: Okay. Now, this was announced -- and I remember this fairly well because I think it was a day or two before we had a hearing before the House Judiciary Committee, but wasn't it announced in April, the .2 percent decline? Or I think it was announced there was not going to be any change at all in April; is that right?

MR. WASHBURN: I believe the traditional

announcement of rate changes is made at the annual meeting; am I not right, Doctor?

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: Which is when?

MR. WASHBURN: Which happens in April of every year.

DR. CLEMENTI: Yeah, second week of April.

MR. WASHBURN: So it is not concurrent with anything that may be going on in Springfield, as much as it is concurrent with the annual meeting of the Medical Society? No, of ISMIE.

DIRECTOR MCRAITH: So it was determined at the annual meeting by whoever attends the annual meeting? I mean, is there a vote, or is this a -- an annual meeting of the board of directors?

DR. CLEMENTI: There's the annual meeting that's held in conjunction with there's a board activity, and then there's an annual meeting. This is of ISMIE, which --

DIRECTOR MCRAITH: Okay. And it's the ISMIE board that interacts with the consulting actuary and the certifying actuary, and then gets a recommendation from the in-house actuary; is that right?

DR. CLEMENTI: We have -- the Insurance Services board would make a recommendation to the ISMIE board after our rate committee has met, which was in the earlier part of April, first Wednesday of April we met. They meet after us. We made a recommendation to them that there was to be this particular increase or decrease.

DIRECTOR MCRAITH: You made the recommendation based on what your actuaries told you.

DR. CLEMENTI: Based on the actuaries, and those -- the discussion that was made, yes.

DIRECTOR MCRAITH: Okay. Now, that minus .2, that does not reflect a change in the actual amount paid by a physician or a surgeon. For example, if Dr. Washburn opens his shop in -- or has a practice in Kane County, it's not -- his rate is not going up or down this .2, is it?

DR. CLEMENTI: He may, but he may also be in the area where there were larger or lesser increases.

DIRECTOR MCRAITH: Okay. So it's fair to say, then, that this change -- percentage change in annual premium volume is a -- is the result of a fairly exhaustive process by ISMIE and it's board; is that a fair statement?

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: Everyone from ISMIE agrees with that?

MR. WASHBURN: We hope we've shown you that, yes.

DIRECTOR MCRAITH: Yeah. My first question about that rate then is, if my notes are correct, we just saw slides talking about the return on surplus, the net underwriting leverage, combined ratio, the paid losses and ALAE by accident year, investment yield, all of which, as I understood it, said that ISMIE's financial condition is not where it should be. Wasn't that the point ultimately, Mr. Gross, of your slide presentation?

MR. GROSS: The point, from the perspective of rating agencies, that's what I was pointing out, and in relation to other companies. You know, what we do internally in terms of setting goals, you know, may be different from other companies, and that would be reflective of what our financial performance is expected to be.

DIRECTOR MCRAITH: Right, right. And I guess that's what I'm getting at. The comparisons to other companies maybe don't mean that much when ISMIE

is saying this is -- I mean, that was a very well thought out, articulate presentation about ISMIE's status and its condition and how it got -- how we get to today, and I thought I understood that ISMIE's condition really wasn't, compared to the industry, as favorable as it could be, and yet -- I guess that then inspires the question, why is there a minus .2 percent change in annual premium volume proposed in April, which is even before this leg -- the recent legislation was passed? I mean, am I missing something? Or, I mean, is there a strategy or business practice that I should know about?

MR. MORSE: Director, if I may, the rates, as Dr. Clementi indicated, are set and were set annually at that time of year, whether the legislature is meeting or not, whether they are just doing a budget year or not, whether there's any legislation pending concerning malpractice or not. In April of that year, as is standard practice of the company, rates are set based upon the data available, the existing law at the time. Every year --

DIRECTOR MCRAITH: No, I understand that. I'm sorry --

MR. MORSE: If I may.

DIRECTOR MCRAITH: Sure.

MR. MORSE: Every year, within that gross -- that total amount of premium that is recovered, you have some physicians who are retiring and no longer paying premium. There may be some younger physicians coming in, paying a lower premium based on their step; although with the moratorium, it's a limited number of new ones coming in. You have some physicians who are scaling back their practice, going to part time. There are some physicians who are altering their practice to eliminate some surgical procedures and the like. So it is difficult, if not impossible, to look at a receipt of .2 percent less than the prior year, and see much other than normal market trends.

DIRECTOR MCRAITH: Right. And I'm not disputing that. What I'm trying to understand then is, the depiction of ISMIE's financial status that we saw in these slides is that ISMIE's comfortable being in that place. Regardless of what the rest of the industry is doing, that's where ISMIE wants to be in 2005; is that right?

DR. CLEMENTI: We try to set rates for individual doctors as individuals. We try to

identify from that individual base what we think the rate ought to be. We then come to a conclusion, and it comes to .2 -- a negative .2 percent. We are willing to say, yes, we don't need to make a large profit, we don't need to make a large surplus, we don't need -- what we need is to have the availability to our insureds and to rate them appropriately, and it's almost like it's two processes. We're not setting the rates just to make a profit because that is not our goal. Our goal is to deliver a product to the individual physician.

DIRECTOR MCRAITH: Can we -- just to -- let me stop you for a second. When you say profit, you mean surplus.

DR. CLEMENTI: I mean -- I mean -- see, the point is, a return on surplus should -- there should be some increase in surplus. There should be some -- 1 percent, 2 percent, some increase showing that the company is building its base so that it can improve some of the ratings that we've had on other factors. So that's what we would like to be able to do, but it's not a matter of increasing 10 percent or 20 percent the base rate or any individuals within the group who we think will bring us up to that

particular level. It's not profit oriented. It's with the idea of what is the best rate for what we need to cover the individuals. Now, maybe that isn't a very good business attitude, maybe --

DIRECTOR MCRAITH: No, no. Look, I'm just trying to get a sense of that financial picture that we saw up there about ISMIE. ISMIE is comfortable with that position.

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: Right?

MR. GROSS: Yeah, maybe I can put it in perspective. You know, the rating committee and the boards made their decision on rates based on the actuarial data that was presented. One actuary had indicated a 1 percent --

DIRECTOR MCRAITH: We're going to get to that.

MR. GROSS: Okay.

DIRECTOR MCRAITH: Yeah, we're going to get to that.

MR. GROSS: We adopted no rate -- base rate increase, and what happened, as we went through and put all the new rate structure in place, it generated an amount of premium that was about the same as what

it was before we put the rates through. So it's more or less a neutral rate action. And what we showed you on the chart that started out with 403 million of projected surplus -- or premiums, we expect that to produce for us about a 4 percent return on surplus, which we are comfortable with. What I tried to point out in the financial comparisons is that 4 percent is behind what other companies charge. But we as a company have made a decision that that is the level that we would be comfortable with.

When we go to meet with A.M. Best, that's not necessarily the kind of message that they're comfortable with, but, you know, they understand, and that's why we have a negative outlook with them, and that's why we have a rating that's below a lot of other companies. But, you know, they respect us nonetheless, and, you know, they -- we share with them information, and they monitor our results, and, you know, we're comfortable with maintaining the relationship with them. And I just wanted to point out that, you know, that position that we take is not the same as what other companies do.

DIRECTOR MCRAITH: Okay. I think you've answered my question. I mean, that when --

regardless of the graphics and the story and all that, ISMIE is comfortable with where it is financially. It's where it wants to be, or else its rate -- its percentage change in annual premium volume would be different.

MR. WASHBURN: It is not trying to make up for that, yes, that is correct.

DIRECTOR MCRAITH: Right. Okay. If we could look at Exhibit 1 in your -- in the binder, and page three of Exhibit 1 which is tab 1-B. And if we skip around -- are you able to find that? This is the chart that Rate Change Indications by Component. Do you have that, Mr. Washburn?

MR. WASHBURN: Right.

DIRECTOR MCRAITH: You got that? Okay

MR. WASHBURN: We do.

DIRECTOR MCRAITH: And we will be going through the exhibits in a different order than they are compiled in your binder, and that's only because I don't think like everyone who has helped me prepare for this. So if we jump around a little bit, you'll just have to bear with me.

Why don't we start with -- is it fair to say, Mr. Washburn, that this table on page three,

that continues on page four, is really kind of the critical information of the rate filing in terms of how the rate is set and what components comprise it?

MR. WASHBURN: I would say that has the major components for a rate filing, yes.

DIRECTOR MCRAITH: Okay.

MR. WASHBURN: Or for how we determine our rates, that is correct.

DIRECTOR MCRAITH: This table has the major components for how ISMIE determines its rates; right?

MR. WASHBURN: That is correct.

DIRECTOR MCRAITH: Okay. Could someone identify just generally what this table is? In more detail than what Mr. Washburn just did, but --

MR. GROSS: Yeah, what is --

DIRECTOR MCRAITH: I don't want an itemized breakdown yet. We'll get to that.

MR. GROSS: What it is, is it's -- it's all the factors that go into the development of the premium rate for a Class 5 physician in Territory 1, starting with the expected frequency, and going through the average costs of claims closing, and all of the various expenses that have to be factored in to bring the premium up to what's needed to cover all

of our costs on a per policyholder basis at that base rate.

DIRECTOR MCRAITH: So there's nothing -- there's no factor not included in this table that goes into the rate making; is that right?

MR. GROSS: Right.

DIRECTOR MCRAITH: I mean, separate and -- excuse me?

MR. GROSS: You could take this, and actually develop the bottom line by applying all the various formulas to each one of the numbers in here.

DIRECTOR MCRAITH: Now, if I'm right, though, this basically -- not basically, it identifies the components of a base rate; is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: All right. What is the base rate?

MR. GROSS: It's the -- in this case, it's the amount of premium that would show up as what a physician that's Class 5 in Territory 1 would pay without any other factors to consider.

DIRECTOR MCRAITH: And it's Class 5, Territory 1 because Class 5 has the most

practitioners in that class; right? And that's internal medicine; am I right?

MR. GROSS: For the most part, yes.

DIRECTOR MCRAITH: And other -- what's the other, do you know?

MR. GROSS: There's some general practice.

MR. ALLPHIN: It's primarily internal medicine, no minor risk procedures. There are some -- there are a very small number of people who are rated in that class who are similar to internal medicine, but for one reason or another don't want to be called internal medicine practitioner, want to be called something else, but the risk is similar.

DIRECTOR MCRAITH: Okay. All right. And we will talk more in detail about the classes and territories. I'm just trying to get a sense of why Class 5, Territory 1 is the base rate, and it's because Territory 1 has the largest number of practitioners; right? And Class 5 has the most practitioners within Territory 1 --

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: -- is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: But this base rate

doesn't actually tell us what a doctor in -- internal medicine doctor physician in Cook County actually pays, does it?

MR. WASHBURN: On an individual basis, no.

DIRECTOR MCRAITH: On an individual basis it doesn't; is that right?

MR. WASHBURN: It does not.

DIRECTOR MCRAITH: Okay. So if I'm a doctor -- I mean, it basically tells the doctor or tells us what the start point is.

MR. WASHBURN: That is correct.

DIRECTOR MCRAITH: But then the rate might increase based on factors -- there are credits or debits; is that right?

MR. GROSS: Yes.

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: Is there a list of the credit and debit factors in the rate filing?

MR. WASHBURN: There is a Manual of Rules and Rates in the rate filing, which includes the list of credits and debits, and how they're applied.

DIRECTOR MCRAITH: Okay. So if I were -- if Dr. Washburn were in Cook County, he's an internal medicine practitioner, how does he go about

determining from ISMIE what his rate will be?

MR. ALLPHIN: Dr. Washburn would need to fill out an application for insurance and submit it to us. We'll review that application. We would check his -- check the prior loss history, see what claims or suits that the applicant has had in the past. We would make a determination as to whether or not that physician is insurable. We might say no, and that's one track, and we might say yes. This is, of course, subject to the exceptions to the new business moratorium. Okay. The exceptions of which are joining an economically integrated group that we already insure, or a physician who is in practice for the first time.

Once we've determined whether or not the physician is insurable, if they are insurable, then we would determine what the rate will be, and that will depend on whether or not this is a mature claims-made individual or a first year or somewhere in between, whether the physician qualifies for part time, what county they practice in, what specialty they practice in, whether they're already joining a group, whether they're joining a group that already has a credit available to them. Those are the

variable factors that go into what the final premium would be.

DIRECTOR MCRAITH: Uh-huh. Okay. Do you know -- or does any ISMIE representative here have a sense of what is the highest premium paid by an internal medicine physician in Cook County? Without knowing the name, do you have -- do you know what that is?

MR. ALLPHIN: I'd have to -- I don't want to guess, Director. I would rather look that up and provide that to you.

DIRECTOR MCRAITH: All right. Yeah. I'd be interested, if you could, in letting me know what the highest and lowest actual premiums paid are for Class 5, Territory 1. Do your -- the indemnity -- I'm sorry. The claims with indemnity, the severity, do you know whether that increased, or can you tell whether that increased from 2004 to 2005?

MR. GROSS: The factors that went into the rate development --

DIRECTOR MCRAITH: Right

MR. GROSS: -- did increase.

DIRECTOR MCRAITH: Okay. Is that visible on the table?

MR. GROSS: Yes, it's the fourth line. It shows that it was 600,000 prior to the rate change, and it's at 640,000 as part of the components of the rate for this year.

DIRECTOR MCRAITH: What percentage of your insureds have a policy with a $1 million limit as opposed to something less than that?

MR. ALLPHIN: It's in the 70 percent range.

DIRECTOR MCRAITH: Okay.

MR. ALLPHIN: For one million limits.

MR. GROSS: At least one million.

MR. ALLPHIN: At least a million limits, yes.

MR. GROSS: We have not very many under --

MR. ALLPHIN: Yes. Two million/four million is another 2400 or so.

MR. GROSS: But they also have a million.

DIRECTOR MCRAITH: When you calculate your indemnity costs annually, do you factor in or consider the increased costs of healthcare?

MR. GROSS: Inflation does factor in to the development of the loss trend.

DIRECTOR MCRAITH: Just looking at average indemnity $1 million limit, which is line four on

this table, and it -- I think that first column we don't really need to look at. That basically shows that that was the -- Class 4 was the base rate the preceding year, but in 2005 there's a change to Class 5; is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: But the base rate is the same, 600,000, and then proposed for 2005 is $640,000; right? Is that $600,000 base rate for Class 5 based on the loss experience?

MR. GROSS: It's probably an answer the actuary should respond to.

MR. CONWAY: It's a combination of all the relevant experience from past years. So it's not just one year, it's a combination of looking at multiple years.

DIRECTOR MCRAITH: Okay.

MR. BICKERSTAFF. Going back to -- from 1995 forward, we were tracking average indemnity at the million limits on or about 400,000. It was ranging 400 down to 380 up to 420. Then into the 1999 to the 2002 area, it was up in the 500,000, and with a few bumps up and down it's gradually been increasing every year along that trend line. So basically the

640 was a reflection of that ten-year trend.

DIRECTOR MCRAITH: Uh-huh. Yeah, I guessed that much, but my question is whether the -- when you have a trend in increased indemnity, do you factor in the increased costs of healthcare?

MR. CONWAY: There's a general process for capturing inflation that impacts insurance losses. There's no direct link between increased healthcare and what is included in the actuarial projections. At some root level, if you can say forces are causing increases in healthcare are causing increases in the cost of insurance losses, then there's a link, but it's -- that's more of a fuzzy link, I guess I would call it.

DIRECTOR MCRAITH: So the 6.7 percent increase for the base rate is the anticipated change in indemnity for 2005 into 2006; is that right?

MR. WASHBURN: That is correct.

MR. GROSS: Those will be indemnity payments that get paid out as much as over ten years is the ultimate.

DIRECTOR MCRAITH: And as Mr. Bickerstaff and as Mr. Conway explained, the actuaries are going to look at, maybe for ISMIE, a ten-year trend; is

that --

MR. BICKERSTAFF: At least.

DIRECTOR MCRAITH: At least a ten-year trend. And then the projection for 2005 is really based on a series of assumptions; right? The actuarial formulas that are applied to the historical data; is that a fair description?

MR. CONWAY: It's based on the results of actuarial calculations that have assumptions embedded in them, yes.

DIRECTOR MCRAITH: From what I understand about actuarial science, which is admittedly very limited, it's true that two actuaries could look at the same historical data and come up with different conclusions; right? Is that a fair statement?

MR. BICKERSTAFF: That's fair.

MR. CONWAY: Yeah.

DIRECTOR MCRAITH: In fact, different actuaries could apply different assumptions or different formulas to the same set of historical data?

MR. CONWAY: Yeah, there's multiple actuarial methods that are available.

DIRECTOR MCRAITH: Yeah.

MR. BICKERSTAFF: There are multiple methods, but generally, the assumptions are in the same ballpark.

DIRECTOR MCRAITH: Within a range.

MR. BICKERSTAFF: Within a range, yes.

DIRECTOR MCRAITH: Right. Right. I learned all about that. There's a zone or range for reasonableness for actuaries?

MR. BICKERSTAFF: Well put.

DIRECTOR MCRAITH: Yeah. And I expect that -- well, Mr. Conway, you're with Ernst and Young; am I right? And, Mr. Bickerstaff, you're with your own firm; is that right?

MR. BICKERSTAFF: Yes.

DIRECTOR MCRAITH: Then ISMIE has its own in-house set of actuary --

MR. WASHBURN: In-house actuary.

DIRECTOR MCRAITH: In-house actuary. And that is maybe a reflection of -- actuaries, I don't mean to insult you in any way, but perhaps the science itself is not an exact science, it's -- you're predicting the future. It's impossible, really, isn't it?

MR. BICKERSTAFF: Agreed.

DIRECTOR MCRAITH: Can actuaries -- and again, forgive my ignorance, but can actuaries form or determine an appropriate rate based on a results-driven approach? In other words, could they say we want to have a minus .2 change this year, that's where we want to end up, let's fashion our formula and assumptions around that?

MR. CONWAY: There's a specific set of procedures or considerations that actuaries are supposed to take into account when they put together a rate projection, and backing it -- backing into the answer isn't one of those.

MR. BICKERSTAFF: Just to clarify a little bit the minus .2, if I may. The actual decision reached by the committee, the doctors committee -- the Rates and Reserve Committee, to which we report our results, was that we would target a no change overall, which is -- which is what our initial calculations resulted in, but then in addition to that, we had a few changes in class relativities, territory relativities, changes in the partnership/ corporation charge that you mentioned earlier. All of these things -- some went up, some went down, and all of those structural changes netted out to be a .2

percent overall decrease; whereas, the base rate was left at the same.

DIRECTOR MCRAITH: That's kind of what I'm getting at, Mr. Bickerstaff. I mean, the -- you have a target based on history; right? I mean, you have your historical data that might have showed that frequency and severity did not increase in 2004 or from 2003 to 2004; right? Isn't that what your data showed?

MR. BICKERSTAFF: Well, as Mr. Gross displayed on the board earlier today, there are six or seven components that we use to build the rate up, frequency --

DIRECTOR MCRAITH: I understand that, but --

MR. BICKERSTAFF: Some went up, and some went down, and the net effect of all those different components turned out to be about a zero.

DIRECTOR MCRAITH: Right. And what about frequency and severity, was there any change from 2003 to 2004?

MR. BICKERSTAFF: When you say a change, there's a change, as indicated on that page, in what our projected severity is from what our projected severity was a year ago.

DIRECTOR MCRAITH: Right, right, but I'm not talking about projections. I'm talking about actual difference. Was there an actual difference in frequency and severity in 2003 to 2004?

MR. WASHBURN: Frequency you can probably tell because you know how many claims. In severity, nobody is quite sure because we haven't even started to pay out for the 2003 to 2004 period. You make assumptions on what the severity will be based off estimates of our payouts.

DIRECTOR MCRAITH: Right, right. Mr. Gross, did you want to say something?

MR. GROSS: Yeah. I think what happens, there's a lot of dynamics that go on in a calendar-year period. What the actuaries do is, they look back at what has happened, back to different policy years, to see how that projects forward. So what we see happening in one year is not always indicative of how it's going to impact the trends that they pay.

DIRECTOR MCRAITH: Am I correct, though, that -- Dr. Clementi, do you sit on the Rate and Reserve Committee?

DR. CLEMENTI: Yes, I do.

DIRECTOR MCRAITH: That you consider more than just what the actuaries report to you when you determine what an appropriate rate change would be; is that right?

DR. CLEMENTI: The actuaries give us -- no, that's not. The actuaries give us a base of information. We try then to look at all the data that they supply, and to decide individually about insureds. Some of the policies are handed down from ISMIE as far as loss-free discounts and other aspects of it. So all these factors go into -- it is a process of using the data that we have, and then turning around and trying to set an appropriate rate, yes.

DIRECTOR MCRAITH: So the actuaries then understand that ISMIE's business model puts them comfortably in that financial position that we saw on the slides, and the committee approves then what the actuaries formulate or what they recommend.

DR. CLEMENTI: Policies are dictated by the Insurance Exchange Mutual and the Services board, and the rate committee follow those particular rules, right. We have procedures that we have for, you know, what our policy -- what the policies are. The

policies are determined by the Exchange. The --

DIRECTOR MCRAITH: What I'm trying to get -- and forgive me for interrupting. Do you rely on your -- when your actuaries say you should have a negative .2 annual percentage change in your annual premium volume, do you just follow what your actuaries tell you?

DR. CLEMENTI: We follow what they tell us because they are the experts in the area.

DIRECTOR MCRAITH: Did the actuaries report to your committee and say there should be a minus .2 percentage change in annual premium volume this year?

DR. CLEMENTI: If they came in with that type --

DIRECTOR MCRAITH: I'm not asking if. Is that what -- forgive me.

DR. CLEMENTI: Did they.

DIRECTOR MCRAITH: Is that what they did, and how did your committee react?

DR. CLEMENTI: First of all, there are two actuarial -- actuaries. Each one made their own, determination. One was a little bit higher than the 0. One was a little bit lower than 0. -- or one was at 0. And we took all these factors into

consideration, and we made our rate determination on all the data.

DIRECTOR MCRAITH: When you say all the data, though, are you referring just to the data that your actuaries gave you, or is there other data that you consider?

DR. CLEMENTI: I would say it is -- it is only from what the actuaries give us. I'm trying to think of what other sources there might be, but I don't know.

MR. GROSS: The actuaries provide the input down to the discount -- provide the information that goes into the numbers down to the discounted premium -- pure premium line. If there is anything that we feel we need to incorporate in there below that line, we would certainly talk to them about it, make them aware of it. But the contingency margin, as an example, or the discount off balance number, those are numbers that we generate, and we need to make sure that we build into that rate in addition to be able to make sure that we can cover all of the expenses that they would not be trending from the losses.

DIRECTOR MCRAITH: So you -- below the --

which line on that -- I'm sorry. Let's look at Exhibit 1-B.

MR. GROSS: Okay.

DIRECTOR MCRAITH: Which factors are provided by your actuaries, and which factors are provided to your actuaries? Just go line by line.

MR. GROSS: The one, two, three, four, five, six -- the first eight or nine lines really come from -- first eight lines come from the actuaries.

DIRECTOR MCRAITH: Okay. And then everything below that is from the --

MR. GROSS: We provide input on, but certainly with their knowledge of what we're putting in. We provide them those factors.

DIRECTOR MCRAITH: You give your actuaries those factors, and then --

MR. GROSS: Yes.

DIRECTOR MCRAITH: -- they incorporate --

MR. GROSS: Yes.

DIRECTOR MCRAITH: -- those factors into your rate making.

MR. GROSS: Yes. When the committee on rates and reserves meet, we go through if there's any changes in those factors. You know, we make sure

that we cover those with the committee so they're aware of all of the aspects that are built into the rate. The actuaries are -- you know, they talk about the numbers down to the discounted pure premium line.

DIRECTOR MCRAITH: Uh-huh.

MR. GROSS: And they'll provide any input that they feel appropriate on any of the other factors.

DIRECTOR MCRAITH: Dr. Clementi, is it fair to say your committee has never rejected a rate proposed or formulated by your actuary or an actuary for the committee?

DR. CLEMENTI: To say we've never rejected it, there are recommendations that they make from their particular suggestions. Have we taken a different number? Have we -- I mean, we have, as you know, an internal actuary who also helps us to try to get to, you know, what we're thinking is -- what our thinking is as well. So we're having advice from outside which makes it as objective as possible, and then some internal aspect as well. But have we ever taken a rate that they have -- have we ever not taken a rate that they have suggested? Yes. And that would be in a situation where we felt as though there

was other factors in the rating that they were not supplying us, they were not giving us. So the point is, we -- for example, we might choose a number that's halfway between two actuarial numbers. I mean, it might be with the idea of trying to find a common level because they don't come in with the same conclusions.

DIRECTOR MCRAITH: Understood. What factors does the committee consider when it decides to do that?

DR. CLEMENTI: You know, if you were to say to me what specific factors, it is listening to what their presentation is, and trying to make a determination as to where we would like to be in our particular --

DIRECTOR MCRAITH: When you personally make that determination, what factors do you consider when you get an actuary saying it should be five points above and another one saying five points below, for example? What do you personally consider -- if you don't know what the committee as a whole considers, what do you personally consider?

DR. CLEMENTI: Personally, I would look at the presentation of each of the actuaries. I try to

establish what I think, you know, they're using, are they being ultra conservative, are they being nonconservative, and try to establish a particular level that is appropriate. That is -- and again, with recommendation from all the in-house people that we have. We have underwriting and claims and finance who all give us advice as to what they think might be a more appropriate line to follow and what might not be.

DIRECTOR MCRAITH: Uh-huh. So you'll take into consideration then what your claims people report to the committee, you take into consideration what your underwriting people report to the committee, you take into consideration what your investment people might report to the committee --

DR. CLEMENTI: Yes.

DIRECTOR MCRAITH: -- is that fair to say?

DR. CLEMENTI: Investment probably not, but the other categories -- I think investment committee is really not even part of Services. It's part of the Exchange. But as far as the other factors, claims activities and underwriting, you know, what they have seen in the way of changes, certainly, in the class determinations.

DIRECTOR MCRAITH: Looking at the table again -- if we could return to the table that's on Exhibit 1-B. The 6.7 increase on projected increase in average indemnity, and forgive me if you explained that and I didn't understand it, but does that 6.7 -- does that proposed increase include the anticipated increase in healthcare costs?

MR. BICKERSTAFF: It includes everything that is included in payments. We do not attempt to break it down into components of healthcare costs, lost wages, et cetera, et cetera, or noneconomic damages, at this point at least. We simply track the end result of all of these factors that go into that value over at least ten years, as I said earlier. We are not attempting to break it down into individual separate trends, but just to have a trend, an end result of all of them.

DIRECTOR MCRAITH: To what extent do the projections of average indemnity -- let me back up. When you review -- when your policyholders have a $1 million limit, at what point does the reinsurance kick in? At $500,000; right?

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: Did I understand that

correctly?

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: So the average indemnity with $1 million limit, and if that's proposed to be $640,000, does that include indemnification from the reinsurers?

MR. GROSS: It's total ground-up cost.

DIRECTOR MCRAITH: Total ground-up cost.

MR. GROSS: Yeah.

DIRECTOR MCRAITH: So it does not factor in what ISMIE would collect then in reinsurance on that claim.

MR. GROSS: It's the total cost of that claim, right.

DIRECTOR MCRAITH: Total cost of that claim, but exclusive of reinsurance collections; is that right?

MR. GROSS: Yes. Well --

MR. WASHBURN: Because your reinsurance is on a swing rate. That means that as we pay -- as they pay, we have to reimburse them for a percentage. So when we're looking at it, it doesn't include reinsurance at all.

DIRECTOR MCRAITH: Does not include

reinsurance at all.

MR. GROSS: Right.

DIRECTOR MCRAITH: So that $640,000 projected -- and I want to make sure I understand the impact of reinsurance on the indemnity. As Mr. Skinner explained earlier, I think the maximum exposure for ISMIE on that 640 would be 500; am I right? Plus prorated expenses.

MR. SKINNER: It's 500 per lawsuit.

DIRECTOR MCRAITH: Right.

MR. SKINNER: We may have three guys in that lawsuit, each with a separate limit.

DIRECTOR MCRAITH: Understood. But we'll talk about how to define a claim a little later.

MR. BICKERSTAFF: Mr. Director, we have to collect -- we're talking about a base rate at the million dollar limit.

DIRECTOR MCRAITH: No, I understand.

MR. BICKERSTAFF: We have to collect that premium at the 500 in order --

DIRECTOR MCRAITH: Right. But my question is whether that average projected indemnity reflects -- or whether ISMIE incorporates into that projection the reinsurance collections.

MR. WASHBURN: At this time, no.
MR. BICKERSTAFF: At that juncture, no.
DIRECTOR MCRAITH: But those collections have been coming in since 2003; am I right?
MR. WASHBURN: But you've got to understand that for the 2005-2006 period, we would have to renew that policy in October.
DIRECTOR MCRAITH: I do understand that.
MR. CONWAY: If you did reflect the reinsurance by lowering that severity number, and then build back in reinsurance costs separately, would you get a different answer, and --
DIRECTOR MCRAITH: But I think -- I don't want to argue with you, Mr. Conway. I understand your point.
MR. CONWAY: Okay.
DIRECTOR MCRAITH: But I think that the insurance -- the cost of insurance, as I understand it, already -- the reinsurance's already reflected in the premiums in addition to the contingency factor.
MR. CONWAY: No.
MR. WASHBURN: No, sir.
DIRECTOR MCRAITH: That's what I understood earlier. Did I misunderstand something? I asked

where was the cost of the contingency. Where is the cost of reinsurance reflected in what -- in the ISMIE world?

MR. BICKERSTAFF: And I think Mr. Washburn answered that by saying that 7.6 percent is not in total the cost of reinsurance. That's just the residual amount above that which is reflected in our premium.

DIRECTOR MCRAITH: Well, do you know then what percentage of this proposed indemnity would -- let me ask you this: What would be the cost of reinsurance for an indemnity of $640,000, do you have a sense of what that would be?

MR. WASHBURN: I don't.

MR. BICKERSTAFF: I don't follow exactly the question.

MR. GROSS: It's not consistent with the way we develop it.

DIRECTOR MCRAITH: Mr. Conway suggested that the 640, if we were to carve out the reinsurance, would be 500, but that we should then add to that 500 the cost of the reinsurance for the loss.

MR. CONWAY: I didn't give you any exact numbers. I said if you limit the cost of that,

reduce the cost of that severity to reflect reinsurance, okay, and then instead, in a contingency load, just reflecting what I would call the off balance due to reinsurance or the extra amount that the reinsurer was going to take, that's kind of the method that follows. There could be another method that would work just the same where you would take into account the reinsurance in that severity you see, and then add, in the full cost of reinsurance, an additional amount besides the off balance that you saw would be the full cost that ISMIE is expending for reinsurance, and what I'm saying is that it would get to the same bottom line answer in terms of rate.

DIRECTOR MCRAITH: You're saying that your reinsurance costs are no different from -- the reinsurance costs don't provide any benefit to the policyholder.

MR. CONWAY: The primary --

MR. WASHBURN: Let me put it this way: The reinsurers do not think they are going to lose money to us. When we buy their reinsurance, they take a look at our claims as well as we do. They anticipate that they will make money on the reinsurance they pay us. They have not always been successful at that.

We have indeed garnered money from the reinsurer in excess of what we paid them. But for the most part, reinsurance -- you do not buy -- you buy your reinsurance to take out some of the volatility of the market, not necessarily for them to reimburse you for claims that you've not paid them for. So when you're trying to develop a rate, you're trying to look at what those claims are going to cost. Then you're going to have to negotiate with the reinsurers what they think those claims will cost. They rarely will give up the benefit of their projection without additional cost. So reinsurance is a plus to try and come up with a rate.

DIRECTOR MCRAITH: It's a plus for whom? Is it a plus for the policyholder to have reinsurance?

MR. WASHBURN: It is a plus for the company to have protection of reinsurance over and above because it takes some of the volatility of the company -- some of the volatility of the marketplace away from the company.

DIRECTOR MCRAITH: I understand that. But what I'm trying to understand is, this is -- we're looking at a table that establishes all the components or identifies all the components for a

rate; right?

MR. WASHBURN: Right.

DIRECTOR MCRAITH: Where in this -- on this table, is there a benefit to the policyholder for the reinsurance that's purchased by ISMIE? Where is that reflected in the rates?

MR. CONWAY: There's two --

DIRECTOR MCRAITH: Is it reflected in the -- is the stability -- the lack of volatility -- the protection from volatility that ISMIE now has because of the reinsurance, is that reflected in the table here?

MR. CONWAY: Without the reinsurance, the contingency load would have to be even larger to maintain the same level of protection.

MR. WASHBURN: Right. Right. We could not have as small a margin as we anticipate without having the effect of less volatility from the reinsurance. We could not take that chance.

DIRECTOR MCRAITH: Let's just go through this. I'm trying to understand the -- where's the cost of reinsurance reflected in the rate that's set? What I've heard right now is that it's -- I mean, it's in the .09; right?

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: Contingency loading. Where else is it reflected on this table?

MR. WASHBURN: It is not reflected on that table anywhere else.

DIRECTOR MCRAITH: The protection that ISMIE has from the volatility, which it understandably wants, that is not reflected in the rate other than in the .09 contingency load; is that right?

MR. WASHBURN: That is correct.

DIRECTOR MCRAITH: Am I -- again, forgive me if I should understand this and I'm not, but is the cost of reinsurance reflected in the fixed expense?

MR. CONWAY: No

MR. WASHBURN: No.

DIRECTOR MCRAITH: Is it reflected in the variability expense factor?

MR. GROSS: No.

MR. WASHBURN: No.

DIRECTOR MCRAITH: So let me ask again the question. I think it's a simple question, but maybe it's too simple for this discussion today. But what is the benefit to the ISMIE policyholder for the reinsurance purchased by ISMIE?

MR. WASHBURN: It is a more stable insurance company --

(Brief interruption.)

DIRECTOR MCRAITH: You have that effect on people.

MR. WASHBURN: I always have. We have a more stable insurance company because of the reinsurance, but that is the benefit to the actual policyholder. He would not -- for a policyholder on his rate, he would pay that charge if we kept it all net. It doesn't make any difference to a policyholder except that our insurance company, because of the reinsurance we buy, has more stability to it. In a very difficult line, that has -- that is material in terms of losses.

DIRECTOR MCRAITH: But stability is another way of saying that our losses are limited; right?

MR. WASHBURN: Our losses are limited to what we think they will be, and when we buy the insurance -- when we buy the reinsurance, they also rate the product the same way we do. So they've got to come up with a product that -- they look at how much they've got to collect for the expected losses, plus their costs, plus their return on equity, and

that's how they give us a price. It is more than the losses.

DIRECTOR MCRAITH: I understand that price, you've said, is reflected only in the contingency load; right?

MR. WASHBURN: The difference between the losses and our price is really reflected in our contingency load, right.

DIRECTOR MCRAITH: Right. You know what, time got away from me where it's now ten to 1:00. Why don't we take 40 minutes, come back at 1:30.

(Lunch break.)

DIRECTOR MCRAITH: All right. As we adjourned, I briefly mentioned to the ISMIE representatives that in the event that we don't -- there is the possibility at this point -- in fact, it seems like a probability -- that we won't conclude the hearing today. What I want to do is give the interested parties an opportunity to speak today if they desire to do so. We will then reconvene at some later date that we'll agree upon, and resume the examination of ISMIE, but I want to -- I know that there's some third parties who have traveled here today and made an effort to be here, probably taken

time away from their regular jobs to be here, and I want to make sure that they have an opportunity to testify today so we can at least get their testimony on the record. Then, as I said, we will -- to the extent that we don't complete the ISMIE presentation today, we'll resume that when we reconvene, and there will at that point be a possibility, at least, of additional third parties who will want to testify, but we will bring this to an end as quickly and efficiently as we can and with as much -- and adhere to all essential principles of due process in the meantime.

So I had thought initially that I would ask some additional questions, but I think, because of the time, I'd like to ask our interested parties to step up and testify, and I have a list of those of you who are in attendance, and I'll just call names from the list. We'll take you one at a time. First witness -- first interested party, Dr. Arvind Goyal, chairman of the Chicago Metropolitan Physician Group. Good afternoon, Dr. Goyal.

DR. GOYAL: Thank you, Director. It's been very educational for us to hear you raise the right questions. I --

DIRECTOR MCRAITH: Doctor, if I could ask you to stop for a second, let her swear you in.

(Dr. Goyal was duly sworn.)

DIRECTOR MCRAITH: Okay.

DR. GOYAL: Thank you, Director, for allowing me to be here. Wanted to introduce myself. My name is Arvind Goyal. I'm a family doctor in Rolling Meadows, Illinois. I'm chairman of Chicago Metropolitan Physicians Network. I'm also president of the American Association of Public Health Physicians, physician advisor at Alexian Brothers, chair of family medicine department at Northwest Community Hospital, clinical associate professor at Chicago Medical School. In my past life, I was president of the Illinois State Medical Society and chairman of the licensing board.

I was the first family medicine resident at Cook County Hospital in 1972 when the program started. I quit doing ob in mid '80s because of a hard market. I learned that word today. I quit surgery in 2004, which was over a year ago, due to high liability insurance premiums. My premiums were 9,500 for a year in 2002, and for three years preceding that. Today I'm paying $34,000 a year for

my solo practice. It would have been 55,000 a year if I had not given up surgery last year, and I have not had a lawsuit approximately 20 -- over 20 years.

It appears that in addition to the issues that I heard this morning and middle of the day, the physician-owned and sponsored insurance company, the largest one that we heard from this morning, supposed to be for Illinois physicians, does not insure Illinois physicians anymore. It appears that if you have that much monopoly in the market, it would be almost required that anybody who needs insurance, anybody who's licensed properly in the State of Illinois, ought to be able to walk in any time they need to. It appears from outside that one of the reasons that this may have been done as the hard market started is so that competition would not lure away any of the physicians when the market did soften.

The ISMIE policies and high rates also hurt physicians who are not insured by ISMIE. We've done some interviewing of other insurance company execs and salespeople and brokers, and our information indicates that many of the other insurance companies follow the lead of ISMIE as far as the rates are

concerned. It also appears that one of the usual statements we have heard is, well, if we are not strong in the market, ISMIE will not take you back. So in order for us to stay strong, we need to raise our rates, and those rates then are even higher. I believe consumers all over Illinois are losing due to high costs and reduced access.

It also appears that ISMIE is a tightly controlled company by a small cadre of staff and physicians, those physicians who hardly or no longer practice medicine. You heard from chairman of ISMIS this morning who retired the end of last year. It appears that a significant percentage of physicians who are in the leadership may not be actively practicing medicine at this time. As far as the staff responsibilities are concerned, I'm sure they do a good job. However, the jobs pay very well, looking at some of the Chicago newspapers lately. There are double salaries for one-day job for many of the senior staff members, great golden parachutes and bonuses, and I'm sure some of you have seen these kind of headlines in Chicago papers where an indicted chief operating officer gets $4.9 million for quitting the job.

The ISMIE executive staff makes sure the current leadership remains. The leadership hardly changes. The election rules are such that people who want to come from outside and want to make changes in how ISMIE operates, those election rules prevent any new blood or significantly new blood in the governance of ISMIE and ISMIS. Excessive profit margins, policyholders being kept in the dark, books closed. Home mortgages for executives, we saw an article in Crain Chicago recently. Seven-year salary protection for senior execs, again, from the newspapers.

Another problem is being minimal oversight by Department of Insurance until current administration. The directors of insurance in previous administrations were literally selected by ISMIE execs who were chairs of transition committees.

The insurance premiums being spent on campaign donations, lobbying, the ISMIE-paid staffs working on campaign -- campaigns as volunteers, and we are not sure of ISMIE's relationship to the PAC, the medical PAC. The dollars being spent from our premiums on recruitment and retention of Medical Society members, the publication of newsletters that

benefit Medical Society. They're too close for comfort.

I have example of a letter that I would at least like to share with you. We had some complaints that we had written to ISMIE last year, and we received this correspondence. It went to ISMIE. We received this correspondence from ISMIS, but one of them came from the State Medical Society in response. They're all in the same building. They're the same people working for different outfits in one building, and even though there's supposed to be an arm-length relationship, it is not clearly defined. It appears that premium dollars should be spent only for professional liability insurance related matters, whatever those might be. ISMIE profits, we learned from newspapers again, there were $20 million profit a year ago, and that was distributed to raises given to the senior staff members and the board members who are compensated, instead of giving a premium relief. Our premiums went up.

It appears that some new types of policies probably should be encouraged by the Department, possibly some policies with deductible if they will balance our premiums, some self-insurance options

limited that are well protected but defined, and, Director, I would urge that if in your judgment, after the hearings are completed, if you feel that the rates should come down, I hope those rates would be made properly retroactive.

Thank you very much. I'll be delighted to answer any questions that you might have.

DIRECTOR MCRAITH: Thank you, Dr. Goyal. I have a couple questions. First of all, I know you came down from the Chicago area today to testify; is that right? Well, thank you for making the effort to be here.

DR. GOYAL: It was great to travel in the cab at four o'clock, Director.

DIRECTOR MCRAITH: A cab?

DR. GOYAL: Some of us shared.

DIRECTOR MCRAITH: Okay. When talking about salaries for ISMIE, you mentioned -- you said double salaries for a one-day job. What did you mean by that? I didn't understand.

DR. GOYAL: I meant that there are people who work at ISMIE, and they also are salaried concurrently by the State Medical Society, and they're respons --

DIRECTOR MCRAITH: So they're receiving a salary from the Society and from ISMIE, is that what you're saying?

DR. GOYAL: That is correct.

DIRECTOR MCRAITH: Also, in terms of your own background, you mentioned you were past president of the Society; am I right?

DR. GOYAL: That is correct.

DIRECTOR MCRAITH: And chairman of the licensing board?

DR. GOYAL:: That is correct.

DIRECTOR MCRAITH: Was the Society -- what was the relationship at that time between the Society and ISMIE?

DR. GOYAL: The ISMIE and ISMIS chairmen sat on the ISMIS board as ex officio members. I also recall that the ISMIE chairman and the ISMIS chairman sat on the executive committee of the State Medical Society at that time. The legal counsel and other senior staffers also worked for ISMIE, as well as ISMIS. The line was many times blurred, however.

DIRECTOR MCRAITH: What year was this? When were you president?

DR. GOYAL: 1992 through half of '93.

However, I need to add that I was never invited to the ISMIE board.

DIRECTOR MCRAITH: Did you want to be invited to the ISMIE board?

DR. GOYAL: Not knowing what I do now, probably not.

DIRECTOR MCRAITH: Dr. Goyal, again, I appreciate the spirit of your comments. I want to make clear, though, that your comment about the Department and former heads of the Department, without knowing any specifics, I will say that I have found the staff to be nothing but professional, and their regulatory efforts to be nothing but highly professional and replete with integrity, so --

DR. GOYAL: And I appreciate that, Director.

DIRECTOR MCRAITH: Right. You mentioned ISMIE's relationship to the medical PAC. What medical PAC are you referring to?

DR. GOYAL: I believe it's called IMPAC, I-M-P-A-C, and I do not know, and that's the reason I raised it. Maybe in your investigation you can make inquiries. I do not know if ISMIE directly contributes to IMPAC or not.

DIRECTOR MCRAITH: Okay. I don't have any

other questions. I appreciate your time.

DR. GOYAL: Thank you very much for allowing me this opportunity.

DIRECTOR MCRAITH: Absolutely. Dr. Al Mariano. Good afternoon.

DR. MARIANO: Good afternoon.

DIRECTOR MCRAITH: The court reporter will swear you in.

(Dr. Mariano was duly sworn.)

DR. MARIANO: Thank you, Director McRaith, for allowing us to participate in this hearing. I'm here as representative of the medical staff at Alexian Brothers. I recently talked with the president of medical staff, and all I'm going to be speaking about here in testimony all approved by the medical staff.

DIRECTOR MCRAITH: Dr. Mariano, could I ask you to speak up a little bit?

DR. MARIANO: Oh, I'm sorry.

DIRECTOR MCRAITH: Just so people in the back of the room can hear.

DR. MARIANO: I am sorry. I have this cold, and I was kind of under weather, but I thought this a very important hearing, and I think taking

antibiotics and Advil helped enough for me to be here.

DIRECTOR MCRAITH: Good.

DR. MARIANO: So, again, let me introduce myself, you know. That I was past president of the Chicago Medical Society, SOMETHING Park branch. I was treasurer of that same Chicago Medical Society for about five years, and member of the board of Chicago Medical Society, and have been active in the house of delegates of the Illinois State Medical Society, and that's why I cannot look at myself as novice in this regard as far as the Illinois State, ISMIE, and others, but I'm no expert either, nevertheless.

Currently, and for the past five years, I'm chairman of department of surgery. That covers not only the general surgeons, but also the ENT, the ophthalmologies, the urologies. We have a section of podiatry, foot and ankle surgeons. We have a section of cardiovascular surgery and neurosurgery, all of them belonging to my department. So you know, really, the breadth and depth of the people I serve who are all my bosses. And currently, they appointed me as medical director of surgical services at the same

hospital. That then covers the department of orthopedics, as well as department of ob/gyn. So I have more bosses than before.

So then gives you a perspective of the fact that I could -- I have the pulse of the surgeons, as well as department of anesthesia, about their frustration and others, and one of the most important problems that they have that is key in the top of their list, that is so awful that it's really taking out -- a lot of things out of their practice is thinking about this increase and higher premium for malpractice. And so if there is anything in life -- if you ask a doctor, what your most pressing need, you know, is, they will always say we have to do something with an increasing cost of malpractice.

I have seen in the last year or so, from a discussion of clinical cases, they're so important, talking about patients, have turned around to practically how are we going to survive, and so this affects their mode of behavior, their attitude towards patients, and hopefully, it will not cause problem with access, but I can see that number of people are staying away from high-risk cases. I don't know the reason why, but I would suspect that

they want to err on the side of safety, and that means access problem. And a number of them, very experienced people, are retiring early. That means access to quality, experienced people, and so I look at myself and others and patients in the future. They'll be taken care of by not as experienced people as before, and hopefully, more training in the future when people -- but I will be a patient, too, in the future, and so I'm concerned about that, as well as the surgeons and anesthesia that I represent.

Let me just to highlight. Before I came here, I didn't know that I would be receiving faxes at home, but let me read you a representative letter, and I can submit it to you for reference. This from Andrew Roth, who assistant professor at Loyola, and there are others here, but nevertheless, "In the last year," he said -- this a letter to me, but he knew that I would be coming here, so I asked his permission to bring it up here. "In the last year or so," he said, "we have lost some very well-trained and experienced obstetrician and gynecologists due to the inability to afford escalating premiums. In fact" -- and now it's mentioning doctors now, real doctors -- "Drs. Raju, Tomacruz and Kang have retired

much sooner than expected. Drs. Iwanicki and Dr. Chudik have stopped practicing obstetrics altogether, and now only have a limited medical practice," maybe gyn or something.

"I see the effects and toll this crisis has taken on my department members on a daily basis. I'm concerned that if this trend continues, there may not be an adequate supply of obstetricians to meet the healthcare needs of our community. As you know, we are a teaching institution for the Loyola Medical School students. It's almost a universal sentiment among these students that they will not go into obstetrics because of the malpractice situation," and this just to highlight some of the letters that I --

DIRECTOR MCRAITH: Okay. Do you have a copy of that letter for us?

DR. MARIANO: All of these I can submit to you, Director.

DIRECTOR MCRAITH: That would be great.

DR. MARIANO: From the chairman of department of orthopedics, Scott Sagerman. From a big group of anesthesiologists, John Prunskis. From the chairman of department of ob/gyn, Alexian Brothers, Patrick Pozzi. I will leave it up to you

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DIRECTOR MCRAITH: Can we take those copies, or do you want us to make copies of those?

DR. MARIANO: No, I think this is specifically -- thanks.

DIRECTOR MCRAITH: Okay.

DR. MARIANO: All of this increase in malpractice -- and I look at my experience in relation to what information that was provided for me in July 18, 2005 at Time.com. It says -- because I was thinking, why is there so much increase in premium, and then this particular Time.com article says, 5.7 percent increase in payouts among 15 leading malpractice insurance companies starting from 2000 to 2004, and yet there is 120 percent increase in premiums at the same period. Now, is there some disconnect there. So I said it doesn't make sense. So I look at my experience, and this actual experience now. Sometimes it's difficult to get -- oh, here it is. In year 2001, my premium was 36,000 per year. In 2004, it was 106,000, a 300 percent increase. And that is from a company other than ISMIE. Now, ISMIE, however, the quote that they have for me was 40,000 to 50,000 in 2001, and therefore, I

don't like to pay that much, and settle for a 36K per year. And that ISMIE rate of quote in 2004 was 120,000, which is also a 300 percent increase. So the problem is not just one single insurance company, but across the board. It appears that 300 percent increase across the board.

And so my testimony is really to let you know about the plight of us physicians, plus the fact that where one big company says this, somehow others have the same thing. However, the actual dollars there's a difference, and that's why I stayed with an insurance company other than ISMIE at this time. So this concerns us, and so we thought that if you look at my -- since my practice in 1982, I have less than ten cases of malpractice, all of them no loss. That is 23 year. And at that time, I was paying less than 5,000 starting off, and 23 years later, it was 116K, which, on calculation, is 2000 percent increase in 20 years. That's like about 100 percent per year. So there's a serious, awful disconnect, you know, in this experience, and so I thought that this would be important for the Director of Insurance, and I'm glad that you are having this historic, I would say, the first real looking from outside looking into all the

type of insurance, and starting off with what we have now.

So my comment would be that, indeed, we have to be thankful that something is being done during this administration in Illinois. And on behalf of the medical staff, I just want to thank you for this opportunity. I'm ready for questions.

DIRECTOR MCRAITH: Okay. Thank you. I think your testimony was pretty clear. I appreciate your comments.

DR. MARIANO: Okay.

DIRECTOR MCRAITH: Thank you. Hope you feel better. Dr. Richard Moser.

(Dr. Moser was duly sworn.)

DIRECTOR MCRAITH: Good afternoon.

DR. MOSER: Good afternoon. Thank you for the opportunity. I first want to apologize because I'm just a brain surgeon, and everything this morning went way over my head. What I wanted to do was -- well, let me introduce myself a bit. I'm the president of the medical staff at Northwest Community Hospital in Arlington Heights, a hospital with 932 medical staff members. I'm the secretary-treasurer of the Chicago Chapter of the American College of

Surgeons. I am a member of the Chicago Medical Society. I'm a member of the Illinois State Medical Society, and I am a policyholder, a shareholder, of the Illinois State Medical Insurance Exchange.

What I wanted to do was give a personal sojourn of my journey through this situation that we have. In 2002, I was paying a total of 107,000 as a neurosurgeon. In 2003, it was 129,000. In 2004, it was 171,000, and for this year, 175,000. Prior to this, I was with an insurance company that had been brought into our hospital as part of a physician-hospital organization, and that rate was 49,500. That was for three years, and then prior to that, I was with the Illinois State Medical Insurance Exchange, and that was at about 100,000. So I had a brief reprieve that the market forces of competition allowed me to have for those three years before I resumed the ISMIE coverage.

What had happened is that last year I looked at this situation, and I said what am I going to do about it. I think the Lincoln Museum and this being the Land of Lincoln brings the words of Frederick Douglass to mind who said that the limits of tyranny are prescribed by the endurance of those oppressed by

it. So I said that I don't know that I can influence what is happening at a statewide level, I do try, but I said that I am not going to pay any more than twice as much as I would pay for liability insurance in Indiana, Wisconsin, or Iowa. Because I have a Wisconsin license, I do have a rating in that state. I do not practice in that state, and my rating for last year was $63,000, realizing that for that year my insurance premium was 171,000. So it's 63,000 to 171,000, and this is for a state that I practice but a mere -- I mean I live a mere 45 miles from. And I said I'm not going to pay more than twice that amount. I figure that's the premium for living in the Chicago area. I enjoy living in the Chicago area, our families are around the Chicago area, so I'll pay twice as much as I would pay for doing exactly the same thing if I were working in Racine or Milwaukee, and all I could get was nine months' worth of practice before I had already paid more than twice as much as I would pay for doing exactly the same thing in Cook County.

So in January of this year -- because my premium cycle runs from April to April, in January of this year, I went on a -- my liability moratorium or

sabbatical, and I stopped practicing for three months. And I resumed practice again in April, and the reason is that this was necessary so that I would maintain this idea that I shouldn't have to pay more than twice as much. And now with my premium at 175,000, and January comes upon me again, and I suppose I'll have to stop again. I will not pay more than that.

But it brings to mind thoughts that I have for this commission, which is, first of all, when we have the debate about the caps on awards, I told myself why don't we have a cap on premiums. That's what the doctors in the State of Illinois need, they need a cap on premiums. Why can't we set a cap? Certainly, how we are reimbursed is fixed by federal, by state, and by the insurers. So why don't we have a cap on the premiums of physicians. That gives the physicians immediate relief.

When I first proposed that at a meeting of the Illinois Civil Justice League, the ISMIS, and the ISMIE, they thought, well, that was absurd because, well, we would go out of business. And I said brilliant. That would be exactly the thing we need to prove that you're right when you say you're not

gouging us, that you're really giving us the best possible deal you can. Because if we set this cap, let's make it 200 percent, let's make it 150 percent, and you can't do it, then I guess you're right. You know, you're right, the cost of doing business in this state is too high.

Then we'd have to create a self-insurance trust in the State of Illinois to cover the physicians because the physicians would now have to have some insurance. We have to have doctors in the state. Every private entity has gone out of business because there's obviously too much cost. Then we have the real driver for true tort reform because now the cost of that, once the law says that the doctors can't be charged more than 150 percent or 200 percent, and the -- and that's all they have to pay into the state insurance fund, then all the excess cost that goes beyond that will have to be covered by the taxpayers of the State of Illinois, which finally gets the expense back to the people who are benefiting from it. At least it makes a reasonable distribution of the expense. So my first action, why not a cap on premiums? Why not do something that would really help, and do it right away, and make it

effective tomorrow.

The second thing, if you can't do that, I don't know how to get more competition in the state. I don't know what we can do to encourage others to participate in this. I do think that competition is necessary, and I'm sad that ISMS, the Illinois State Medical Society, is so bound to the Insurance Exchange that they cannot see to encourage that kind of competition. Without competition, I don't think we're going to get a significant reduction in our rates.

The liability reform that we have with the caps on noneconomic damages, at best that's going to produce a very small, very incremental decrease. There are a number of things that if we can't have competition and we can't have caps on premiums, then this insurance entity that claims to really do everything it can do for us at every moment, then there are things that it should be able to do for us. It shouldn't require that we have a corporate policy in order to get a group discount. So they give us a 35 percent discount, and then they charge us 25 percent for the corporate policy. So they give us 10 percent off. Why do we need the corporate policy?

We, from our corporate point of view, don't need it. Why not make it optional?

The commissions. Why the commissions? Why? Why is 6.5 percent not given back to us? Why is it that -- I mean, this -- this is a very stable market. The doctors that are in the State of Illinois, why are we paying an extra 6.5 percent? Why can't that be a reduction? Why do we have to pay those commissions? We're not interested in the bond rating. We're not interested in paying those commissions because some broker has to work hard to get whatever their clients are covered by this. We shouldn't have to pay those commissions.

I don't understand the reinsurance issues either, as some other people here struggled with the reinsurance costs. I mean, it's a million/three million or -- well, basically a million/three million is the type of policy coverage that we have. Most reinsurance that I'm aware of is all about unknown risks. I mean, how many doctors do get combined into a suit when you talk about this clash coverage?

And last, I also would like some mechanism for full disclosure. I do worry about what is the relationship between ISMIS, ISMIE, and ISMS. I think

it is a -- it is a curious combination of groups of people who -- I know their intent seems to be that they're doing the best they can, but unless there's pressure put upon them, I doubt that that actually is the case. And I think that they need to look at themselves each day, and say are you really doing the best you can for the doctors of the State of Illinois. Thank you.

DIRECTOR MCRAITH: Thank you. Dr. Moser, first of all, thank you for your comments. It sounds like you've spent some time thinking about these issues. Before -- if I understood correctly, in '99, 2000, and 2001, did you say you paid 49,500 --

DR. MOSER: That is correct.

DIRECTOR MCRAITH: -- in premium, annual premium? And then you moved your coverage to ISMIE in 2002 --

DR. MOSER: That is correct.

DIRECTOR MCRAITH: -- is that right? What was the reason for that move?

DR. MOSER: I was previously with ISMIE when I came into the state, and then our physician-hospital organization at Northwest Community Hospital got together, and basically created a buyer group

that then sought competition, a better rate. So prior to that, I was paying almost $100,000 in the year prior to then, and this three-year hiatus in which we had competition; albeit, they were maybe using us as the loss leader to get into the market that's already been explained us. But for three years we did have this, and it was a very substantial decrease over what I had been paying, and then when I returned to ISMIE three years later because the Firemen's Fund, in this case, had decided to leave the state, and not because of claims against our particular buyer group, but because for whatever reason that insurance companies do this, this didn't seem like a lucrative enough trade. So then I returned to ISMIE after that at almost the same premium I had left them at. So a rather -- a period of stability, and then we came into this era that you've been alluding to, this dramatically escalating premiums, and what the foundation is for that, and what we can do. I mean right now we can say, well, everybody's comfortable, we're -- you know, there's a a huge cash flow being generated at the expense of the doctors of the State of Illinois, but is it a proper generation of that cash flow? Is it truly

needed?

DIRECTOR MCRAITH: Okay. Thank you very much.

DR. MOSER: Thank you.

DIRECTOR MCRAITH: Appreciate your thoughts. Dr. Michelle Kosik. Good afternoon.

DR. KOSIK: Director McRaith, thank you.

DIRECTOR MCRAITH: Sure.

(Dr. Kosik was duly sworn.)

Dr. KOSIK: I very much appreciate the opportunity to speak with you. It's so important to hear from the physicians, as well as from ISMIE, and frankly, the trial attorneys. We have a complicated problem in this state. I have greatly appreciated the comments that have come before me. I agree with many of them, and may touch on a few others.

I am a general surgeon. I'm practicing in Cook County. I've been in practice with my group since I completed my residency in the late 1999. I have had no lawsuits, no claims to date. I have a clean record. I have a good professional reputation, and the group with whom I practice, of which I'm a partner, has been in existence since World War I. It is the premier surgery group in the southwestern

suburbs of Chicago.

Over the last couple of years, the malpractice crisis has truly destroyed our group. Because these premiums have risen exponentially while the reimbursement of general surgeons has plummeted, we earn essentially half of what we earned in the late '90s. The financial pressures have been such that physicians are finding that they have no way out. Our group serves a region where we have many uninsured patients, underinsured, and Medicaid patients. Consequently, we are often not reimbursed for the work we do, yet our malpractice premiums still loom over us.

Since these malpractice premiums have skyrocketed, the senior partner in my group has been forced to retire from surgery because he can no longer afford the premiums. This has been a tremendous loss for the community that he served for 30 years, and it's been a loss to each of us who have relied heavily on his leadership and his experience. It was a sad departure.

Also over the last year, there have been stress-related illnesses in my group. Three of my partners are suffering from stress-related

conditions, and they continue to work because they have families to support. I know of physicians in other groups who have become clinically depressed. I even know of a cardiothoracic surgeon in Chicago who has recently committed suicide. The issues that are facing physicians are really serious.

My personal experience is also important. It's somewhat unique. I am one of the few female general surgeons. My rate right now with ISMIE is $102,000 per year. Approximately three years ago, at age 40, I became pregnant, and I cut my work schedule in half because of the physical rigors required with general surgery. At that time I requested a part-time insurance rate from ISMIE. My request was denied. At that time, the first time I've ever requested part-time rates, I was told that approximately 220 cases per year would be considered full time for a general surgeon. My case load was much below that. For six months I had 100 cases, and many of them were minor cases, excisions of skin lesions, noninvasive. Almost half of my cases were small cases. They had low risk, and low reimbursement, and it was still well below the projected 220 cases per year, but ISMIE denied my

request. They said my number of cases was too close to the number of a full-time surgeon, and I should try again in six months. For that period, my average case reimbursement was just over $300 per case, and I have fewer than a hundred cases, as I mentioned.

And so I had embarked on my first year of running a deficit, instead of an income. This would be the first of three years wherein I would work for free or work to pay to work. Even if I had performed the 220 cases, what ISMIE said was a full-time number, at $300 per case, I would have only had $66,000 that year in accounts receivable, and our collection rate in Cook County where I'm practicing is roughly 50 percent. So that would be $33,000, nowhere near covering my insurance premium, let alone overhead, nursing, administrative staff, office expenses, continuing medical education which is due, licensing fees, answering services, pagers, cell phones and the like. To me it demonstrates that ISMIE truly is out of touch with what physicians are facing. For them to look at a general surgeon and say that $102,000 is a good rate and a discounted rate is absolutely outrageous.

Just over two years ago I had my first

child. My daughter was born by Caesarian. I was unable to return to work immediately because of the surgery, and while I recovered on maternity leave, ISMIE charged me the full malpractice insurance rate. It took me and my office manager almost a year of complicated discussions to get them to decrease my rate during the time which I did not work at all. I was surprised to hear that our neurosurgeon is able to quit for three months. When I was off, I was required to pay ISMIE 25 percent of my corporate rate of $4,000 a month and 25 percent of my malpractice rate. It amounted to several thousand dollars per month while I was on maternity leave.

When I returned to work, I continued to work part time. I filled the six-month requirement, and I went back to ISMIE again, applying for a part-time rate. This time I had only 150 cases, but ISMIE told me that I needed fewer than that in order to obtain a part-time rate. So the number on my second request had changed. It had gone from 220 down to 150. When I researched this a little bit more, it turns out that there actually isn't anything in the underwriting that says how many cases a surgeon would do would be part time or full time. The only thing

that I can find and that other professionals can find is a requirement of working less than 20 hours a week, which I can prove by log. ISMIE was not interested. I learned the rules change with ISMIE, and I began my second year of paying to go to work.

I appealed the decision, and I was told that a surgeon would review my request. Indeed, a surgeon with ISMIE did review my case. It was an orthopedic surgeon. I don't think he really had an understanding of what general surgery is. He denied my request. So I continued to work part time. I became pregnant with my second child who is now ten months old. I again delivered by Caesarian section, and I again paid ISMIE thousands of dollars per month while I was off on maternity leave.

It came to a point that I couldn't go on, and I needed to make some changes. So I moved my practice after my maternity leave to DuPage County, out of Cook County. I did this as a solo move. I did not have any contracts. I did not have any referral base. I didn't have any business plan other than to go into the field and meet people and drum up business. I described to ISMIE what this would mean concerning my volume of cases, what it takes for a

surgeon to build a practice. I explained that I would be home with my two babies. I would not be working more than 20 hours a week, and I guaranteed them this. They still would not give me a part-time rate, and I still continued to have this astronomical premium.

Presently, I've completed the six months of work at my new location. Now I have fewer than 70 cases in six months, and I have again started to apply for the part-time rate. My guess is that ISMIE will tell me 70 is not the right number now, too. That's probably pessimistic, but it's my experience. For the third time I'll be trying to apply, and I'm sure for the third time I'll be denied.

But now things are different. I can no longer continue to pay. Effective October 1st, I will not be able to pay my insurance. My malpractice tail is $237,000. In order for me to quit practicing, I need to pay ISMIE $237,000. I still have student loans. I have a mortgage on a house. I have a husband with United Airlines whose future is in the balance, also.

A look around the country instantly demonstrates that we have a serious problem in

Illinois. A general surgeon in Illinois pays $102,000 a year, while a surgeon in Wisconsin pays $23,000. A neurosurgeon in Illinois with ISMIE pays $230,000 per year, while a neurosurgeon in Texas pays 48,000. The fees around the country are oftentimes one fifth of what they are here in Illinois, and these are states that have 250 or $500,000 caps for the most part. So why is it Illinois is nearly the only state who cannot find a solution. It's clear that we agree it's a complex problem, but it's also clear that there are solutions, and it's beyond time that we need to make some changes. Something absolutely must be done.

First of all, the Illinois legislature has decided that they feel high awards for plaintiffs are a must, and if this is the case, then they also must provide malpractice relief to the physicians. Providing good healthcare to the residents of Illinois is as important as providing roads or fire departments, police departments or schools, or any of the other things that the state is responsible to provide. So one solution would be to determine a national average for malpractice premium by specialty, apply that to Illinois, and allow the

physicians to pay that, and have someone else determine where we can get the balance. The state picks it up, self-insurance by the state, or perhaps ISMIE does need to give us some full disclosure, and see if we can't reduce rates in a more direct way.

Alternatively, physicians could be permitted to carry less or no malpractice insurance. This has been in effect for several years in Florida. There is a $250,000 escrow requirement. The patients are all made aware that that is the limit to any pending lawsuit, and the physicians are able to practice without carrying malpractice insurance. Here in Illinois, we are required to carry it, or we cannot have hospital privileges.

Another alternative which our distinguished neurosurgeon touched on is a cap on our insurance premium. Why cannot the insurance premium be a direct percentage of a physician's income. This would give a proportional fee to a proportional risk.

Lastly, the malpractice tail should be abolished. It is forcing doctors into positions where they have no alternatives but to become indentured servants. The choices to leave the state are not a choice when a malpractice tail of a quarter

of a million dollars is pending. The option to go into retirement is only an option for a few in our field, and even quitting would cause me to need to pay my malpractice tail.

Lastly, we also know what doesn't work. What doesn't work are the window dressing types of solutions that are coming forward. Senator Durbin mentioned something about a tax credit. This is not going to help someone like me at all. ISMIE offers a 5 percent or a 10 percent or a 20 percent discount for attending a malpractice seminar. This doesn't help us at all either. A $102,000 premium brought down to $92,000 is still untenable. Governor Blagojevich's recent legislation may not work either. I know in Texas a couple of years ago they had similar reform, and the physicians have received an approximate 10 to 12 percent reduction over the last couple of years. Again, a 10 percent reduction is not going to help the crisis specialties like ob/gyn, general surgery, and neurosurgery. It's important to remember that reimbursement for general surgery is lower than the other specialties, and perhaps the crisis is then greater. An average appendectomy on a Medicaid or Medicare patient pays $600, and there's a

global period for which we cannot charge for anything but that operation. For three months a surgeon cannot charge, regardless of how many visits, how long the hospital stay, how many rounds we make. So our income is capped. Our premiums need to be controlled as well.

I thank you for this opportunity to share my experience. I hope and I trust that you will do what is right. It's a difficult problem, but something needs to be done. We need to be able to provide quality healthcare to our good citizens in Illinois, and we need to help the plight of the doctors. We are here to help people, we are here to serve, but we also need to survive. Thank you.

DIRECTOR MCRAITH: Thank you. Dr. Kosik, I have a couple quick questions. Did you begin paying premiums in 1999 --

DR. KOSIK: Yes.

DIRECTOR MCRAITH: -- did I understand that correctly? So this -- the $237,000 for long-tail coverage is from 1999 -- for claims that might arise from '99 through --

DR. KOSIK: Correct.

DIRECTOR MCRAITH: -- October 1st?

DR. KOSIK: Correct. I believe the statute of limitations is around seven years. My initial premium was in the 30 -- low 30s, and then increased up to the current rate of 102,000. Since the legislation has been passed here in Illinois and signed by the Governor, we have just received an increase of 15 percent at my -- at my group.

DIRECTOR MCRAITH: From ISMIE?

DR. KOSIK: From ISMIE. So we went from 89,000 to 102,000 effective October 1st. Earlier, you were talking about a corporate rate as well, and we, too, sat down with our insurance broker and said we can't afford to pay the corporate insurance. It's $4,000 per physician per month, and we just can't afford it. And they said, well, you can get rid of that, but then we'll raise your single rate up to the same number. So that seems like a scam to the physicians as well.

DIRECTOR MCRAITH: When you say we, are you referring to --

DR. KOSIK: My group of six surgeons.

DIRECTOR MCRAITH: In the southwest suburbs?

DR. KOSIK: Yes.

DIRECTOR MCRAITH: I thought you had left

that practice. Did I mis --

DR. KOSIK: I'm still a partner in the practice, but I am trying to build and practice at hospitals that are outside of the Cook County area.

DIRECTOR MCRAITH: Okay.

DR. KOSIK: And I still am on staff at the hospitals where our group is on staff.

DIRECTOR MCRAITH: And the group rate, you said, went up 15 percent?

DR. KOSIK: Yes, 15 -- 15 percent. Roughly $15,000.

DIRECTOR MCRAITH: And when did you receive notice of that increase?

DR. KOSIK: I believe we received notice in July that it would be going up, and it was effective October 1st.

DIRECTOR MCRAITH: Okay. You made the statement that the General Assembly determined that high malpractice awards are a must. I don't know what you're referring to when you say that.

DR. KOSIK: You know, I mean a $500,000 cap is, from a physician's standpoint, not as good as a $250,000 cap, and there is certainly a long history here in Illinois of shooting those down. The Supreme

Court finding it unconstitutional, and caps being previously shot down through the jury system.

DIRECTOR MCRAITH: And then one final question. When you were interacting with ISMIE, did you deal with ISMIE through a broker or producer, or did you --

DR. KOSIK: I did.

DIRECTOR MCRAITH: -- contact them independently?

DR. KOSIK: I did, and there were times I contacted them independently, but usually, I went through my broker.

DIRECTOR MCRAITH: Has your group had one broker for the -- all the time you've been connected with the group?

DR. KOSIK: Yes.

DIRECTOR MCRAITH: All right. Thank you very much.

DR. KOSIK: Thank you.

DIRECTOR MCRAITH: Dr. Tom Pliura. Tom Pliura. Okay. Brent Adams.

(Mr. Adams was duly sworn.)

MR. ADAMS: Thank you for giving me the opportunity to be here today. I have written copies

of my testimony if that would be of use to the Director or the court reporter, as well as to any other interested party here today. My testimony will deviate from it only slightly in light of testimony that's been presented today.

My name is Brent Adams, and I'm the policy director for Citizen Action Illinois. Citizen Action is the state's largest progressive public interest coalition. Our members represent a wide array of consumer interests, and include labor originations, community and religious groups, women and minority groups, senior organizations, health organizations, disability rights groups, as well as gay and lesbian, environmental and rural groups.

Consumer interests are at stake in at least two ways at today's hearing, both of which we believe ought to weigh in determining whether ISMIE's rate filing is sufficient and whether the rate increase is justified.

First, as to the company's rate filing. Corporate disclosure and transparency is important for consumers because it empowers them to hold corporations accountable for their business practices. This principle is embodied in the new

medical malpractice law SB 475 insofar as the documents and information that ISMIE is required to produce are to be made available to the general public. Yet only a highly trained expert could, upon reviewing ISMIE's rate filing, evaluate the economic soundness of the company's rate-making methodology, and that is my first point.

A significant portion of the general public ought to be able to review these documents and learn something. Independent actuarial certification is important, but should not stand as a substitute for transparency and accountability. Consumers should ask: So the actuary's reviewing the insurance company, but who is reviewing the actuary? Admittedly, these are highly technical issues, but I believe the information could be provided in a more helpful way. The Power Point that was presented today does encompass some of the issues I'm going to mention. Hopefully, we'll have the chance -- I will have the chance to look at that at a later date. So to the extent it's duplicative, we can set aside those requests. But Citizen Action Illinois requests the Department use its authority to obtain additional information from ISMIE, including real examples of

the actual rate that physicians in certain specialties and certain areas of the state will be expected to pay as compared to the rate they paid in prior years, taking into account surcharges, discounts, and changes to class rate relativities.

Second, we would like to see in this rate filing ISMIE's total amount of anticipated losses, including expenses for the current policy year. A slide presented earlier today did contain a financial summary. However, we think as a matter of course the rate filing ought to include that information at the get go. We would also like to see expenses broken down in detail, commissions, defense costs, employee salaries, executive compensation, marketing, PR, as well as these same expenses for their related companies, ISMIS and what have you. ISMIS being I-S-M-I-S.

And finally, the company's overall profit for the preceding year, and profit -- the definition of which probably needs to be standardized in some way -- and the company's forecasted profit for the current policy year. We believe this information ought to be presented in summary form, similar to the manner in which information is presented in Form

RF-3, in order to enable a higher percentage of the general public to understand what's going on here. Little discussion has, as of yet, been given to the effect of the caps on noneconomic damages, so I would like to request that at some point ISMIE discuss the degree to which its actuarial assumptions have or have not, will or will not change in light of those caps.

Now, as to the justification for the rate itself. In the debate over SB 475, and in particular the debate over caps on noneconomic damages, ISMIE and the other proponents of that legislation promised that this new law would increase access to quality, affordable healthcare, and this promise is embodied in the legislative findings to SB 475. Both because of this promise and because ISMIE bears the burden of proving that its rate increase is justified, we believe that the company ought to present some analysis of how its rate increase will affect access to healthcare. In other words, whether a rate is justified ought to take into account the health needs of the community being served by the provider whose rates are being increased. For example, a 4 percent rate increase in an extremely underserved area ought

to be viewed less favorably than a 4 percent increase in a well-served area. In reviewing ISMIE's rate filing, I saw terms like territory relativities, class plan definitions, present value factor, contingency margin, claims-made maturity factors, and off-balance factor, but the word "health" is, for the most part, conspicuously absent. Health impact ought to be a factor in evaluating whether a rate increase is justified.

Citizen Action Illinois believes that today's and future rate hearings should not be lessons in actuarial science, but rather should consider rate increases as they impact the health and well-being of the general public.

Thank you for allowing me to be here today, and thank you to ISMIE for working to ensure that the goals of SB 475 are realized. We realize that this is an uncharted territory, and we thank you for your patience and diligence. Thank you.

DIRECTOR MCRAITH: You mentioned that health -- the health impact ought to be a factor in the rate analysis. Can you be more specific?

MR. ADAMS: Information regarding the served or underserved communities was certainly presented in

the context of the debate over SB 475. So that analysis is, to a large extent, available with respect to areas where doctors are leaving the state or what have you. So areas that have been identified where that is particularly problematic ought to be considered in light of the rate filings. Particularly, I don't have the data at hand, but with respect to rural parts of the state, with respect to certain specializations, the data is available as to where the most dire needs in terms of those health services lie.

DIRECTOR MCRAITH: Do you recall, Mr. Adams, from your constituents and what they reported what specialties were most in need, or whether -- where there appeared to be -- what specialties -- what area -- what specialties were not serving areas where they were needed?

MR. ADAMS: Well, ob/gyn is the most noted example.

DIRECTOR MCRAITH: Are you aware of any others?

MR. ADAMS: Not offhand.

DIRECTOR MCRAITH: And do you know what areas?

MR. ADAMS: What areas of the state?

DIRECTOR MCRAITH: Yeah.

MR. ADAMS: Unfortunately being from Chicago --

DIRECTOR MCRAITH: I don't mean to put you on the spot.

MR. ADAMS: No, that's okay. Being a Chicagoan, anything downstate is sort of downstate to me. So downstate is all I can say is my best assessment.

DIRECTOR MCRAITH: Okay. Thank you very much.

MR. ADAMS: Thank you.

DIRECTOR MCRAITH: Did Dr. Pliura return to the room? I know he was very interested in participating. Why don't we take -- we've been going a little while. We don't we take about five minutes. It's five to 3:00. Let's take five minutes, and we'll resume.

(Short break.)

DIRECTOR MCRAITH: Mr. Washburn, if you and your colleagues want to rejoin us. Dr. Pliura is not here, so -- okay. I have -- ready to --

MR. WASHBURN: Yes, sir.

DIRECTOR MCRAITH: -- resume? Okay. Did you have any specific comments in response to what we've just heard from the interested parties?

MR. WASHBURN: I think we'll probably want some, but I think we'd like to take a little time, sort of work them out, if we can.

DIRECTOR MCRAITH: Okay. I heard Dr. Kosik say that she was on maternity leave, and had to pay a premium or a portion of her premium while she's on maternity leave. Is that a fair statement of ISMIE's business practice?

MR. ALLPHIN: Typically, when a physician is on leave, and that can be for a variety of reasons, that can be for illness, that can be for additional education, that can be for travel, we reduce the premium to 25 percent of the manual premium. We call that the suspended coverage period. Policy continues, but the premium is reduced 75 percent from manual.

DIRECTOR MCRAITH: Why is there a premium charge if they're not practicing, and they're on leave? I don't understand that.

MR. ALLPHIN: Well, there's a --

DIRECTOR MCRAITH: There's no potential

liability for any incident during that time period.

MR. ALLPHIN: And that's why it's reduced for that time frame, but there still is the possibility that claims will be reported during that time period from events that occurred when the physician was practicing.

DIRECTOR MCRAITH: Right, but that's why you collect premium for while she's practicing; right?

MR. ALLPHIN: Right.

DIRECTOR MCRAITH: So why are you collecting premium for a period of time when she's not practicing, she's on maternity leave?

MR. ALLPHIN: We're reducing the premium to reflect the --

DIRECTOR MCRAITH: But it -- I'm sorry. Go ahead.

MR. ALLPHIN: We're reducing the premium to reflect the decreased exposure.

DIRECTOR MCRAITH: But her premium, say, was a hundred and -- if I understood correctly, it was 102,000 a year. So if her premium is reduced to 25 percent, Mr. Allphin -- and I'm not trying to quibble with you. I understand what you're saying. I'm trying to understand why she's paying $25,000 for a

period of time when she's not practicing. They're not -- you've already collected premium for the time period when she is practicing.

MR. ALLPHIN: Well, we are collecting the premium in order to keep the policy in force because this is a claims-made policy. If she were to cancel the policy at that time when she went on maternity leave, she would have to buy tail at that point in order to continue the coverage. This is an opportunity to keep the policy in force at a much reduced cost as opposed to buying tail, canceling the policy and buying tail.

DIRECTOR MCRAITH: You mean if you have an insured who goes on maternity leave, she's either got to pay 25 percent of her annual premium, or she has to purchase tail coverage?

MR. ALLPHIN: Yes, that's correct. That's true for anyone who is either ill or takes a leave for whatever reason.

DIRECTOR MCRAITH: Okay. Thank you. I was also intrigued by her statement that for her to quit she'd have to pay $237,000 for tail coverage. Did you think that was a fair statement? For a general surgeon who's not had any claims, and has practiced

for, I guess, a grand total of five years, including her maternity leaves, which were, as she described, two in the five years.

MR. ALLPHIN: Yeah, I believe she indicated that her retroactive date was 1999.

DIRECTOR MCRAITH: Right.

MR. ALLPHIN: Okay. So that means she's been in -- she's had coverage with us for approximately six years. The tail factors that are part of our rate filing, they're like two and a half of expiring premium. So the number that she quoted makes sense, given what -- given what I know about her circumstances at this point.

DIRECTOR MCRAITH: Okay. Two and a half of her expiring premium?

MR.ALLPHIN: Expiring premium.

DIRECTOR MCRAITH: What does that mean?

MR. ALLPHIN: The tail factor is a factor of two and a half times a physician's expiring premium.

DIRECTOR MCRAITH: And that's to account for the fact that medical malpractice claims have a long tail?

MR. ALLPHIN: Yes. In essence, when you buy tail, that converts the policy into basically an

occurrence policy, and that's the premium charge for that.

DIRECTOR MCRAITH: Again, forgive my ignorance, but if Dr. Kosik is paying $102,000 annually for coverage, that's based, as I understand, on the projections that are, for this year, contained in this table, what the anticipated -- or the average indemnity might be, and all these other factors that we'll talk about in more detail; right?

MR. ALLPHIN: Uh-huh.

DIRECTOR MCRAITH: So her premium is based on that, and she pays that premium in full. Then she wants to quit, and you're saying she needs to pay more for claims that might come up for policy years during which she's already paid the premium?

MR. ALLPHIN: That is correct because this is a claims -- this is a claims-made policy.

DIRECTOR MCRAITH: Right.

MR. ALLPHIN: And once it stops, you must either buy tail or not buy tail. You're not obligated to buy tail, but if you do not buy the tail, the coverage will cease at that point.

DIRECTOR MCRAITH: And by claims made, you mean the policy will cover claims made during the

year. It's not when the incident occurs, it's when is the claim made?

MR. ALLPHIN: There's actually two triggers. The incident must occur on or after the retroactive date, and the claim must be reported during the time when the policy is in effect.

DIRECTOR MCRAITH: A claim must be reported when the policy is in effect, meaning the incident must be reported by the insured before quitting, in this case; right?

MR. ALLPHIN: Yes.

DIRECTOR MCRAITH: And then the claim must be actually asserted after the expiration of the policy?

MR. ALLPHIN: No, the claim must be -- the claim must be made, and this is reported to us while the policy is in effect or while the tail coverage is in effect.

DIRECTOR MCRAITH: While the policy's in effect or while the tail coverage --

MR. ALLPHIN: Either -- in either case. Okay. If you have a policy that's in force, a claim can be reported while the policy is in effect.

DIRECTOR MCRAITH: Right. And that's

covered by the premium that you've paid during that policy year; right?

MR. ALLPHIN: That is correct.

DIRECTOR MCRAITH: So the tail coverage is for coverage after the policy expires; right? After you leave ISMIE, so to speak?

MR. ALLPHIN: That's correct.

DIRECTOR MCRAITH: And then covers you into infinity or --

MR. ALLPHIN: That is correct.

DIRECTOR MCRAITH: -- is there an end point on the tail policy?

MR. ALLPHIN: No, it's into infinity.

DIRECTOR MCRAITH: When you calculate the tail coverage premium, do you -- you base it on the premium. It's 2.5 percent -- two and a half times the final year premium; is that right?

MR. ALLPHIN: That is correct.

DIRECTOR MCRAITH: Okay. So that will already include whatever discount factors might apply; is that right?

MR. ALLPHIN: That is correct. It will include discount factors for loss-free discount, as well as risk rewards.

DIRECTOR MCRAITH: So for an insured like Dr. Kosik, who didn't have any claims during her entire -- as I understood it, her five years less the time she was on maternity leave, but she paid premium anyway, she gets -- there is no additional discount, or she doesn't receive any discount for tail coverage when she requests it?

MR. ALLPHIN: I don't believe -- I'm not clear on whether she qualifies for any discounts under the policy at this point, but if she did --

DIRECTOR MCRAITH: Just hypothetically.

MR. ALLPHIN: If she did --

DIRECTOR MCRAITH: If she didn't have any claims for five years, then she wants to purchase tail coverage, is it based on that fifth year premium, two and a half times the fifth year premium?

MR. ALLPHIN: That's correct.

DIRECTOR MCRAITH: And that formula is not adjusted upward or downward based on number of prior claims?

MR. ALLPHIN: No, it is not.

DIRECTOR MCRAITH: So it's at least conceivable that you might have someone, say, for example, like Dr. Kosik, who doesn't have a claim for

five years, and you collect, in that fifth year, $102,000 from her, and then you collect an additional $237,000 from her, and there's never a claim against her at all? That's at least conceivable; right?

MR. ALLPHIN: That is conceivable.

DIRECTOR MCRAITH: So you will not expend one penny for Dr. Kosik in five years, and then you're going to collect another $237,000 from her for -- to cover her for the rest of her life?

MR. ALLPHIN: That is correct.

DIRECTOR MCRAITH: Okay. How many -- Mr. Allphin, I'm not sure if you're the person to ask this question, but -- so I don't mean to put you on the spot inappropriately, but how many people --

MR. ALLPHIN: I seem to be on the spot.

DIRECTOR MCRAITH: How many insureds actually leave ISMIE in each year and purchase tail pol -- long-tail coverage?

MR. ALLPHIN: Well, let me just say that we -- that the number of policyholders who leave us during a given year varies from year to year, it's not the same number every year. In '04, it was about 900 that left us, and I think we had -- I tell you what I'm going to ask, I'm going to ask is that you

allow me to give that information to you.

DIRECTOR MCRAITH: Okay. What I'm really interested in is how many people purchase -- how many insureds purchase tail coverage at the end -- at the expiration of their policy. I mean, that -- so if you could, if there's a way to get me that, I'd like to --

MR. ALLPHIN: We can get you that information, Director. That's not a problem.

DIRECTOR MCRAITH: All right. Thank you very much. Thanks.

MR. WASHBURN: But just -- Director, just in case, there is a time when you do not have to purchase tail; is that correct?

MR. ALLPHIN: That's correct.

DIRECTOR MCRAITH: When is that?

MR. ALLPHIN: That is when you die. At one time --

DIRECTOR MCRAITH: That's a relief. That's quite a concession, I might add.

MR. ALLPHIN: Actually, one of the physicians once said -- one time I said if you die, and they all sort of laughed because they know that's really nonsecular. Death, total disability, and

retirement, retirement from active practice. In those circumstances, you can -- in death and disability, you can get the tail absolutely without cost. For retirement, it depends on how long you've been insured with ISMIE. If you're 55 years of age, and you've been insured with us for five consecutive years, you will get retirement tail for free, or at any age, if you've been insured with ISMIE for ten consecutive years.

DIRECTOR MCRAITH: And that's regardless -- the retirement segment, the retirement group -- of those three, the people who retire, they don't have to pay for tail coverage regardless of their loss experience?

MR. ALLPHIN: This benefit does not relate to loss experience at all. If you die, you will get it. If you are totally disabled, you will get it. If you retire, you will get it. Irrespective of how many claims you have had reported under your ISMIE policy.

DIRECTOR MCRAITH: Do you find or does ISMIE -- is ISMIE able to track whether the loss experience of physicians increased as they age?

MR. ALLPHIN: I can speak to that

anecdotally. What we typically find is that as physicians are winding down their practice, they tend to reduce the risk of things that they're doing. They let the younger guys take the tougher cases, they don't get up in the middle of the night like they used to. They tend to just ratchet it down a little bit, knowing that, you know, I'm going to slowly, you know, pass this onto my -- to the people who are coming behind me. But I can only speak to that anecdotally. That's typically what we see.

DIRECTOR MCRAITH: Okay. I guess I'm -- I mean, that's -- I appreciate the anecdote. I'm trying to get at -- does anyone in your group, Mr. Washburn, know whether the loss experience of a physician increases as they age?

DR. CLEMENTI: Question would be at what age are you talking about. Is it between 45 and 55? Is it between 55 and 65? Is it between 65 and 70? You know, they're probably all different, and to get data from each of those groups, you'd almost have to do it by specialty because there's probably a difference, and you'd be ending up having a smaller and smaller group, and you really can't get any significant data that means anything.

DIRECTOR MCRAITH: I'll take your word for it today, but I tend to think it's probably a fairly easy question to answer, you know, and what I -- I guess the reason I'm asking the question is, you offer free tail coverage to physicians who retire regardless of their loss experience.

MR. WASHBURN: That's correct.

DIRECTOR MCRAITH: Right. And at the same time, you have Dr. Kosik without any loss history at all, spent, what, six months on maternity leave in five years, and she's got to pay almost a quarter million dollars for tail coverage. And then I thought we heard earlier there's no, I think Dr. Clementi said, socialization of insurance, socialized insurance, and I guess I'm tying to understand whether there's some kind of a subsidy there.

MR. WASHBURN: Well, people coming to us will buy --

DIRECTOR MCRAITH: Forgive me if I'm mixing our conversation up a little here, but these are connected concepts.

DR. CLEMENTI: The thing that I don't know if is easy to understand -- it was never easy for me to understand -- when we went from occurrence

policies to claims-made policies. One year we were paying $100,000 for a policy using a number. The next year we were paying 25, and I said how come? We're still being insured, and the whole difference was going from a claims-made -- from an occurrence policy to a claims-made policy. With claims-made policy, the $237,000 is not just money that we're trying to gouge out of her. It's because we know that a claim that she has in the last year of her practice may not show up for another year or two, and then at that particular time, there could be a $500,000 award. On average, a surgeon -- a general surgeon, which is what I am, who practices general surgery, will be sued one out of five years. So she's doing better than the average, but she hasn't stayed with the company long enough to be able to get the rewards, which is the loss-free discount. As time goes along, she would get that loss-free discount, but, you know, she's in the situation where financially she's under fantastic pressure. And I'm going to say, you know, all of these people --

DIRECTOR MCRAITH: Let me stop you there just to clarify, Dr. Clementi, and I don't want to put you personally on the spot, but one of the

doctors who testified said that you're no longer practicing.

DR. CLEMENTI: I retired in January of this year.

DIRECTOR MCRAITH: Okay.

DR. CLEMENTI: Let me tell you. The three people who testified, all three of them, with the exception of the young lady who is a general surgery, all three of them are personal friends of mine. I've known them for years, I've practiced in the same hospitals they did, I worked -- Dr. Goyal and I, he used to refer cases to me. Dr. Mariano and Dr. Moser. All of them are good friends of mine, and I have great, great sympathy for the problem that they're in, but the difficulty that we are -- we -- has been created is, we have to make sure that this company is able to be there tomorrow. So it has to have these terrible rates that's driving people out of practice, and the only reason that we have to do that is because the loss potential is so terrible in Illinois. That's why.

DIRECTOR MCRAITH: Well, I think -- you know, I appreciate your statements. I think the question I asked earlier, and I still haven't heard a

clear answer to is, was there an increase in loss frequency and loss severity from 2003 to 2004. So the potential loss that you're talking about, Dr. Clementi -- or 2002 to 2003. The potential loss you're talking about -- and again, I understand this is a big equation, and we're going to cover all the components, but I don't see what you're saying in the loss frequency and the loss severity. We'll talk about that in greater detail, but I just wanted to say that because of your kind of broad statement there. When did ISMIE change its policies from occurrence to claims made?

DR. CLEMENTI: 1985. '86 was the first year that we wrote a claims-made policy.

DIRECTOR MCRAITH: Was there a change in -- did ISMIE implement a change in actuarial assumptions in 2000 or 2001?

DR. CLEMENTI: Our actuarials will have to answer that. I have no idea.

DIRECTOR MCRAITH: Was there any change in the practices of the actuaries, Mr. Bickerstaff?

MR. BICKERSTAFF: In assumptions or methodology or --

DIRECTOR MCRAITH: Either.

MR. BICKERSTAFF: Assumptions are updated every year, obviously. I think I can speak for all of it. I don't think there's been any change in the basic methodology for many, many, many years.

DIRECTOR MCRAITH: Okay.

MR. GROSS: I would like to add something. I think you have to make sure that you're matching up the premium and the exposures because with somebody that started practicing in '99 was paying first-year claims-made rates. The next year they were paying second-year rates. So those are discounted, you know, because the exposure -- it takes a while for the timing of when the claim occurs until it gets reported. We give them the credit for that in the claims-made premium. That's the benefit they get from that.

The downside would be that as you cumulate years, you're accumulating exposure. So if somebody stops after six years, and then they want to stop, you know, they have -- they've paid discounted premium -- claims-made premiums at lower rates for that period. It's just a matter of the premium catching up with the exposures.

DIRECTOR MCRAITH: Well, let's take Dr.

Kosik, for example, and I think she -- is she -- I think she left. So just someone in her situation. So we'll just use her name since she testified. Five years no incidents, and again -- I mean, forgive me for repeating this, but you collected $25,000 from her when she's on maternity leave. She pays almost a quarter of a million dollars just to quit. Two years there are no claims made. Does she get any -- does she see anything in return? Does she get anything back after the statute of limitations has expired? Does she see any of that.

MR. WASHBURN: No. No, she does not.

DIRECTOR MCRAITH: And I understand what insurance is all about, so -- but there's something -- I mean, I heard a discussion about the business model, and how, you know, it's almost a philanthropic endeavor, and I'm trying to understand why Dr. Kosik has to pay a quarter of a million dollars just to get out, and she'll never see a penny of that even though she's never had one claim against her.

MR. WASHBURN: We believe -- let me see if I can answer a couple of questions. First of all, from -- we expect the average severity, the indemnity

limit to go from 600,000 last year to 640. So we are seeing that increase. We are looking at the average closed with indemnity going from 1.75 to 1.70, so that we expect -- we are looking at a trend that's going slightly down. At $640,000 an incident, we have, what, 14,000 policyholders? 14,000 policyholders. That's not a lot of claims. I mean we are talking about a small number of claims that are spread among a large policyholder base, and that's the way the process has had to run to pay for malpractice insurance, and I know you understand the law of large numbers, but it is multiplied here with a company that has -- where the average indemnity at one million limit is $640,000 each. It exacerbates the problem, and that's what makes it so very difficult for us to try and estimate, and that's why we sometimes do miss.

DIRECTOR MCRAITH: Well, with all due respect to my actuary friends, I understand it's not an exact science, but I think there are some -- you know, what we're trying to understand is whether -- not just the actuarial formula, but the business realities which comprise, you know, at least half of the table, half of the components of the price.

That's really what we're tying to get at, and I -- and what I -- perhaps in my -- from my layman's perspective, and you'll forgive me if I don't understand this, Dr. Clementi, as well as I should, but when Dr. Kosik pays as much as she did, and had to pay even when she's on maternity leave, if she pays $250,000 almost for a tail coverage and never has one claim, there's some -- I mean, she has to pay that just to get out of the practice of medicine, then, you know, that -- my question is, in terms of a business model, what happens to that money? If it doesn't go back to her, where is --

MR. WASHBURN: It goes to the policyholders' claims.

DIRECTOR MCRAITH: Okay. So your comment, Dr. Clementi, earlier that -- I think you were disparaging the trial lawyers, and I understand this has been a political discussion that predates me by decades, probably, but that there should be -- you know, some people are advocating socialized insurance rates. It sounds like that's happening already.

DR. CLEMENTI: Well, when you say socializing, you mean --

DIRECTOR MCRAITH: That was your word.

DR. CLEMENTI: The word that I was using and it was in reference to saying that we ought to just have one great big pot, and everybody ought to pay some percentage whether you're a general surgeon or whether you're a neurosurgeon, but the point is --

DIRECTOR MCRAITH: That's what I'm saying. I mean, you have Dr. Kosik paying a quarter of a million dollars, and you have a retiree paying nothing for tail coverage.

DR. CLEMENTI: But that retiree has been in practice for 40 years, 30 years.

DIRECTOR MCRAITH: But he pays nothing regardless of his loss experience.

DR. CLEMENTI: The point is, he's been paying throughout that particular period of time. In other words, what it says is, the people who have been with the company, have been willing to understand and to stay with us, that this is, if you want to call it, a benefit. Sort of like the loss-free discount. If you are with the company for ten years and you have no losses, then you will have a discount, but if you haven't been with the company for ten years, doesn't make any difference what your loss experience was in the past. So it really

depends upon what you have paid as an individual into this company. I have paid these rates into this company up to January of this year, and I'm still paying now because I'm a -- I have different coverage. But the point is that -- the fact that I'm retired, it means that I have paid for 35 years into this company.

DIRECTOR MCRAITH: So Dr. Kosik --

DR. CLEMENTI: And I have not had any losses in that period of time.

DIRECTOR MCRAITH: Right.

DR. CLEMENTI: Okay.

DIRECTOR MCRAITH: Dr. Kosik pays a quarter of a million dollars after five years; right? Is she, in her tail -- the premium for tail coverage, subsidizing your --

DR. CLEMENTI: General surgeons who have been in practice five years who have -- in other words, she --

DIRECTOR MCRAITH: I'm trying to get a --

DR. CLEMENTI: -- a class. There's a class of general surgeons.

MR. CONWAY: Can I add something?

DIRECTOR MCRAITH: Please.

MR. CONWAY: As part of our rate makeup, there's a charge in there, and I think you saw it, it's called DDR, and there's a 4 percent of premium, and that money's collected over time. Dr. Clementi's been paying that in every year since 1985. 4 percent of his premium is essentially going towards covering that tail when he retires. So that's where the money comes from. It's not -- it's just paid in a little bit over time.

DIRECTOR MCRAITH: Okay. Where does -- I understand that, and we're going to talk about DDR.

MR. CONWAY: Okay.

DIRECTOR MCRAITH: We can look forward to that, but I'm interested in where does Dr. Kosik's premium go. I understand where that -- the DDR is, and how that factors into the premium paid by every physician who is insured by ISMIE, but where does Dr. Kosik's long-tail premium go? Where does that end up in ISMIE?

MR. CONWAY: There's one pool of premium that's put together to pay all the losses no matter what physician it comes from.

DIRECTOR MCRAITH: Okay. So that then is,

to use Dr. Clementi's word, an incident of kind of socialized insurance.

MR. CONWAY: I wouldn't agree with that.

MR. BICKERSTAFF: No.

MR. CONWAY: Because the premiums that are paid in the first place are, to the best of our ability and the best of the information we have, related to the loss experience we expect from those physicians. So the premium charge is relative to the risk that ISMIE's taking. I think in a socialized insurance example, you could use any allocation of premium to the individuals, but in this case, it's based on loss experience which is the difference.

DIRECTOR MCRAITH: I see, but you said there's one pool of premiums collected to pay the losses.

MR. CONWAY: Well, once the pool is collected --

DIRECTOR MCRAITH: Yeah.

MR. GROSS: Everybody benefits.

MR. CONWAY: Right. Once the pool is collected, but the pieces that made up that pool have been put together based on analyses and based on what we -- the losses we expect those individuals to have

over some long run.

DIRECTOR MCRAITH: Uh-huh. You're aware, I expect, that in -- I don't know who should answer this question. I'd like to have one person answer it, but do you understand the term rate compression? Is there someone who can answer that question?

MR. BICKERSTAFF: I can tell you how we've used it, and the context that we've used that term.

DIRECTOR MCRAITH: Sure.

MR. BICKERSTAFF: Is that over the last, actually, 15 to 20 years, there's been a compression in the relativities between classes from the top to the bottom, generally speaking. The surgical classes related to the nonsurgical classes, that relativity has come down, and conversely, the internists and Class 4, Class 3 have come up. So there's been a compression in the range of rates from the bottom to the top over the past 15 years or so.

DIRECTOR MCRAITH: Uh-huh.

MR.BICKERSTAFF: Is that the context that you were --

DIRECTOR MCRAITH: Yeah, I'm kind of thinking about it more in the concept, though, of one specialty paying premiums that assist in paying the

losses of another specialty. For example, I know that ISMIE breaks its specialties into classes and territories; right?

MR. WASHBURN: Correct.

DIRECTOR MCRAITH: I'm aware that in a state like Wisconsin, the largest medical malpractice insurer in that state has one territory. So rather than six, like ISMIE has in Illinois, Wisconsin has one, and we've already heard from a couple doctors, including the neurosurgeon, how his rates in Wisconsin would be a fraction of what he would have to pay in Illinois. And I guess just kind of as a general question, let me ask, has ISMIE considered that, seeing as it has proven effective in other states for other insurers?

DR. CLEMENTI: The reason for the lower rates in Wisconsin are not because of compression. The reason in Wisconsin is because of the law, and the size of the awards. The size of the awards is what dictates what has to be paid out in Wisconsin, what has to be out in Illinois, and the size of the awards have been tremendous in Illinois.

DIRECTOR MCRAITH: So it's your testimony, Dr. Clementi, that the size of the awards in

Wisconsin -- the severity of losses in Wisconsin is lower than the severity of losses in Illinois?

MR. WASHBURN: Wisconsin has a patient compensation fund that pays part of the awards.

DIRECTOR MCRAITH: Right. I understand. That's not my question. Are the awards for -- to plaintiffs in Wisconsin lower in severity than the plaintiffs in Illinois?

DR. CLEMENTI: It was my understanding. If that's -- that could be wrong. I could be wrong.

DIRECTOR MCRAITH: It's 3:35. I want to just finish up with one line of questioning, and then we'll clarify where we're going to go in our next hearing so everybody is aware of that. But there is a lot of discussion, and there has been, as I understand it, anyway, from reading prior transcripts, about the relationship between ISMIE Mutual and ISMS and ISMIS, and the reason, of course, for the discussion is, to what extent are ISMIE Mutual policyholders subsidizing the operations of these other enterprises, and so I kind of want to talk about that and maybe just to get that stuff out. Is there -- who should -- who wants to answer these questions?

MR. WASHBURN: Probably be the --

MR. GROSS: Yeah, I can speak to that.

DIRECTOR MCRAITH: And we already talked -- Mr. Morse and I already talked about the relationship between ISMS -- MIS and ISMIE, and I understand it's a for-profit company that doesn't make profit. But if you -- I'd like to hear, Mr. Gross, maybe if you want to elaborate on that, and also the relationship between ISMIE Mutual and ISMS.

MR. GROSS: Okay. You're looking primarily at the cost sharing? Because you're talking about one company subsidizing another. So you're concerned about the approach we take to making sure that each company pays their share of the costs, wherever they come from, or whatever they're for, is that your --

DIRECTOR MCRAITH: I'm trying to understand -- what I want to learn about, Mr. Gross, is to what extent do the rates paid by ISMIE's insureds subsidize or pay for something other than the liability of ISMIE's insureds.

MR. GROSS: Okay. When we went through the discussion on the rating process, we talked about the budget of expenses for ISMIE, and that budget actually comes from the whole process of determining

how the costs get distributed between the companies. And all that ISMIE is including in its rate making is the expenses that it is being charged for the activities that it is -- the activities that are taking place for ISMIE, and it starts from the budgeting process. There are several individuals that do perform functions for all the organizations, but we have a very careful process of determining what time gets allocated to each of those companies, and that's actually done through the budget process.

DIRECTOR MCRAITH: Excuse me. Go ahead.

MR. GROSS: And that's actually done through the budget process. And there's a lot -- you know, there's expenses that are associated with employees. There's expenses associated with office space, the use of computer equipment. Everything is carefully identified and allocated appropriately through that budget process. We have to do that for many reasons. We do it for regulatory purposes on the insurance side. We do it for IRS purposes on the ISMS side because ISMS is a not-for-profit organization. So we always have to be careful to make sure that the right company is paying the right expenses.

DIRECTOR MCRAITH: Sure. Am I correct that

the only source of revenue for ISMIS is its contract with ISMIE Mutual --

MR. GROSS: Yes.

DIRECTOR MCRAITH: -- is that right?

MR. GROSS: Yes.

DIRECTOR MCRAITH: And am I -- to what extent does ISMS get subsidized or is it compensated by ISMIE Mutual?

MR. GROSS: Well, there is cost sharing which is done. It's a shared service arrangement between the organizations. And that's primarily based on people's time, and how much they charge for each organization, but then all the other costs associated with that will fall in line, you know, on that basis.

MR. MORSE: Director, if I may, and I apologize, but I believe your specific question is, is there any sharing of expenses or underwriting of the ISMS expenses by ISMIE Mutual, and I believe the clear answer is no, and then let me fill that in. The Medical Society does have an endorsement arrangement with ISMIE mutual, a royalty arrangement, by which the Medical Society endorses ISMIE as the preferred malpractice carrier, and works with ISMIE

in that respect, and gets paid by ISMIE an amount for that. I believe that's $400,000 a year.

MR. GROSS: Yes.

MR. MORSE: I'm not sure about that.

DIRECTOR MCRAITH: That's a royalty, you said? Is it based on the number of ISMS members who sign up with ISMIE?

MR. MORSE: It has not been done -- some are done in some organizations based on numbers. This is not. This is a flat amount that is paid, and has been paid annually, and that is fairly typical for professional organizations to endorse insurance companies or other, you know, products and services for their members, and get some type of compensation for doing so. There is no other subsidization between the companies.

The budgets that are put together by each company, reviewed by each board, is based upon the time those employees whose work is shared put into each company, and that shared services agreement is on file with the Department. The agreement and the arrangement is reviewed every year, has been for over 20 years, by independent auditors for each organization. There have been clean audits for each

organization each of those years. The Internal Revenue Service did what is called a combined examination audit in which they audit all entities that share ownership or facilities or perhaps lease employees from each other. That combined examination audit, which took about three years, and went through the period 1998, looked at this issue with respect -- you know, ISMIE with respect to whether the rates, the tax refund sought at that point was appropriate, and from the Medical Society perspective, looked at it from the perspective of whether the Medical Society was in any way violating the tax exempt status which it had, and the audit came back with no findings on that point, no problems, no questions about that either.

This Department, the Division -- I'm sorry, I still call it by its former name -- also has done an examination with respect to ISMIE and ISMIS, presumptively looking at the expenditures and the like. So there is a shared relationship which in part culturally traces the history of the organization since ISMIE was started by members of the State Medical Society when there was no other availability of coverage, but there also has always

been a close cultural relationship in the fact that these are physician-run, physician-owned organizations, but there is a separation and independent outside review on an annual basis of the expenditures.

DIRECTOR MCRAITH: All right. I appreciate your summary. I have not doubted whether the relationships would pass the IRS mustard. I'm really trying to understand what the relationship is. What expenses are shared? And I understand you said there's $400,000 paid annually by ISMIE to ISMS because the Medical Society identifies ISMIE as its preferred carrier; is that right?

MR. MORSE: Yes.

DIRECTOR MCRAITH: On what is the $400,000 based?

MR. WASHBURN: It's a flat fee.

DIRECTOR MCRAITH: Okay. But, I mean, how is it determined that $400,000 is an appropriate amount? I mean --

MR. MORSE: I believe it was negotiated between the leadership of the two organizations.

DIRECTOR MCRAITH: Between ISMS and ISMIE?

MR. MORSE: The board members.

DIRECTOR MCRAITH: The board members.

MR. MORSE: And in fact --

DIRECTOR MCRAITH: Did any board members have to recuse themselves from that conversation?

MR. MORSE: In fact, each organization went out and retained independent counsel to represent it in those negotiations. Because having a shared staff, to avoid any conflict or appearance of a conflict, they wanted to engage in this relationship, and they each obtained outside counsel to negotiate this arrangement for them.

DIRECTOR MCRAITH: So ISMS, ISMIS, and ISMIE all share office space, they share employees, they share staff; right?

MR. MORSE: Certain staff members. There are some staff members that exclusively work on the insurance side. For example, claims and underwriting. There may be -- I'm no longer an employee there. There may be some staff members that exclusively work on the Medical Society side and exclusively paid by them. And then to the extent that there are services that can be provided to both organizations, or frankly, to all three organizations, there's some staff members that are

compensated for a portion of each day by each of those three.

DIRECTOR MCRAITH: And is that a prospective analysis, or is it retrospective? For example, if Mr. Washburn -- Dr. Washburn were working for ISMIS and ISMIE Mutual, and, say, one day he spends eight hours for ISMIE, and the next day he works six hours to ISMIS, how is the cost of his salary apportioned between the two?

MR. MORSE: Historically -- and, Bud, I apologize if I'm getting into the finance area. Historically, each division would estimate, based on their prior experience, the work that they did for each organization if they work for more than one organization, and put together a proposed budget for each organization, which would go through the normal budgeting process each year, reviewed by each separate board. There is a process for a reconciliation if experience during that coming year -- since the budget is generally approved at the January board meeting for that year, there is a process that would permit reconciliation, and in the shared services agreement, there is a process whereby if there is any disagreement between those

organizations, that the respective chairmen of each board meet together as a committee to resolve any differences. I am unaware of there having -- ever having been a disagreement because the budgeting process of each separate organization entity has tended to track what is being done for each organization.

DIRECTOR MCRAITH: We talked kind of summarily earlier about the financial challenge that ISMIE confronted in 2002 and 2003. Do you remember that discussion? Did I characterize that correctly?

MR. WASHBURN: That's probably a correct characterization, yes.

DIRECTOR MCRAITH: All right. Were there any efforts by ISMIE or ISMIS to reduce costs during that time period, or was it an effort -- or was it instead a decision to increase rates? And by costs, I mean some -- you know, these costs that are on the table here, and we haven't itemized, for example, what goes into the fixed expense or the variable expense factor, but was there an effort to -- or strategy to reduce any of those costs in 2003?

MR. GROSS: Well, there's always an effort to make sure that you're keeping your costs down, and

there's always a directive from the boards to do what you can to -- well, certainly be able to do better than what the budget is, and the budgets are always evaluated on a regular basis, and -- but you're talking about at a time when we had a significant increase in exposures, too. We also have to make sure that we're continuing to provide the service that we need to provide. So we did look in all areas of the organization to determine what we could do to keep the costs down.

DIRECTOR MCRAITH: Okay. Did this -- I mean, one of the reasons I ask is, at the same time that you increased the rates, the moratorium was imposed, and so that seems to me like you're trying to tighten your belt in some way, and at least limit your exposure, as I understood, based on the number of additional insureds. And was there a specific effort, though, to reduce, for example, the fixed expense? Has that number of 725, has that changed at all from, say, 2002 to 2005? Has it gone up or down at all?

MR. GROSS: That number has stayed constant for quite a period of time, but the adjustment for it is done in the variable expense factor.

DIRECTOR MCRAITH: Right. And has that increased or decreased, Mr. Gross, at all in the last few years?

MR. GROSS: The variable expense factor did go down a few years ago, and certainly in that 2002-2003 time frame I think we saw a decrease in that as, you know, percent of the -- or relative to exposures.

DIRECTOR MCRAITH: Okay. Was there staff that was let go at all, or was space reduced at all? I'm just trying to get a sense of whether these expenses were specifically considered when -- in 2003.

MR. GROSS: Well, in the budget process, we always have to make sure that we're doing what we need to do in putting the staff in and the resources to cover all of the areas that need to be taken care of, and we did see a growing increase in exposures over a period just prior to that. Underwriting did not go out and hire a bunch of people during that process. So at one point, I think you could say that they probably had, you know, a higher than normal load. Also, along with the growth and exposures, we started seeing increase in the number of claims

outstanding. You know, we need to make sure that we're addressing that from a claims support perspective, too.

So when we go through the budget process every year, we do look at the activity that's going on in claims and underwriting, and we look at what our staffing needs are relative to the amount of activity, and we make sure that they're matched properly.

DIRECTOR MCRAITH: Well, I mean, that begs the question, Mr. Gross, and again, I don't mean to put you on the spot, but you said that the variable expense factor decreased in 2002 or 2003, as I understood it, you weren't sure which year, but at the same time that you're saying that the number of claims increased.

MR. GROSS: Yes. Well, claims is handled through the other factor, the -- there's a ULE loading which is really the one that handles the claims support functions.

DIRECTOR MCRAITH: You know, why don't we -- unless you have an answer right now --

MR. WASHBURN: I don't think we've got the -- we did not bring the information for 2002-2003

with us that I'm aware of.

MR. GROSS: Well, in the report that we gave you, you can see that the percent of premiums that was identified for claims unallocated expense went from 3.5 percent in 2002 to 3.2 percent in 2003, and the underwriting administration portion went from 3.6 percent of premium to 3.3 percent of premium, and it went down again the next year to 3.1. So I mean there's been some response in the -- at least in terms of premium.

DIRECTOR MCRAITH: Okay. Has the -- was there any change when -- as I understood it, there was an inaccurate expectation of loss frequency and severity, right, and that's why there was a sudden -- I mean, the increase in 2003, that was the dramatic increase of, I think, 35 percent; is that right? Was there any change in leadership? I mean, that sounded like, you know, a several-year problem kind of culminated in 2002. Was there any change in leadership with the company because of that? I mean, that's a fairly significant mischaracterization -- not -- miscalculation, it seems like, and I'm just wondering was that a result of leadership failure, or was that -- what was -- you know, committee failure?

What was the problem?

MR. WASHBURN: We still have the same actuaries that we had at that time.

DIRECTOR MCRAITH: Okay.

MR. WASHBURN: I think that you'll see through the insurance industry there was a problem with the ability to track what was happening with severity. I mean, our actuaries could probably answer that better, but the actuarial assumptions that we made at that time were incorrect over a period of years, and we had to pay additional money into claims reserves for that in -- culminating 2002-2003.

MR. GROSS: And we saw a very unusual situation occur at that time. We saw a significant increase in frequency and a significant increase in severity all at the same time.

DIRECTOR MCRAITH: Right. And I've heard that. There has not been an increase, though, in frequency or severity, say, from 2002 to 2004, I don't believe; is that right?

MR. WASHBURN: We anticipate there's an increase in severity from 2003 to 2000 --

DIRECTOR MCRAITH: To 2004?

MR. GROSS: And we have --

DIRECTOR MCRAITH: I know you anticipate it, but I'm talking about actual data that we have on hand right now. I think we've already covered this. From, say, 2003 to 2004, the data doesn't show an increase in frequency or severity.

MR. WASHBURN: I don't know whether that's -- I don't know whether that's a correct characterization.

MR. CONWAY: Yeah, I would say our actuarial analysis shows that we believe it's a variable increase through that time period.

DIRECTOR MCRAITH: Right. No, I understand that the projection is that it will.

MR. WASHBURN: There is no actual data on which we can base the yes or no answer.

DIRECTOR MCRAITH: The experience of 2004 effects the proposed rate for 2005; correct?

MR. CONWAY: That and the prior years, right.

DIRECTOR MCRAITH: And the prior years.

MR. CONWAY: Yeah.

DIRECTOR MCRAITH: And you base -- all the prior years are on actual experience; correct? When

you talk about prior years, you're basing it on actual --

MR. CONWAY: Well, as you go back in time, you've got more and more information on what the final payouts in those years are going to be.

DIRECTOR MCRAITH: Okay. All right. Why don't we wrap it up for today. It's just short of four o'clock. We will identify a date to reconvene. Anybody who wants a transcript of today's proceedings can speak with Robin. Thank you for your time and your patience.

We need -- before we concluded, though, we need to identify exhibits, get them identified on the record. We will, at the next hearing, focus more specifically on the rate filing, and some of the assumptions in the rate filing, as well as some of the actual loss data. So my hope is that when we resume that not only will my questions be more narrowly focused, but the responses will be.

MR. WASHBURN: You're not out of questions, I take it, Director.

DIRECTOR MCRAITH: I am not out of questions. Okay. So if you'll bear with us for one minute, this is going to be somewhat ministerial, but

we need to identify exhibits for the record.

MR. WAGNER: Director, for your consideration is Exhibit No. 1, which is ISMIE Mutual Insurance Company Rate and Rule Filing, effective July 1, 2005.

Exhibit No. 2 is the five-year historical data for ISMIE Mutual Insurance Company.

Exhibit No. 3 is a Notice of Hearing in Hearing No. 05-HR-0771 for ISMIE Mutual Insurance Company.

Exhibit No. 4 is Notice of Hearing in Hearing No. 05-HR-0772 for ISMIE Indemnity Company.

Exhibit No. 6 (sic) is the Entry of Appearance for Attorney Saul Morse in Hearing No. 05-HR-0771, ISMIE Mutual Insurance Company.

Exhibit No. 6 is Entry of Appearance for Attorney Saul Morse in Hearing No. 05-HR-0772, ISMIE Indemnity Company.

Exhibit No. 7 is 2005-2006 Rate Study, dated March 9, 2005 by Ernst and Young. Rate study of ISMIE Mutual Insurance Company.

Exhibit No. 8 is a report, also from Ernst and Young, on estimates of class and territory relativities.

Exhibit No. 9 is the Rate and Rule Filing, effective July 1, 2005, for ISMIE Indemnity Company.

Exhibit No. 10 is the statement of Jay Angoff, of counsel, Roger Brown and Associates, dated September 27, 2005.

DIRECTOR MCRAITH: You got -- ISMIE, you will be able to obtain copies of all of these exhibits.

MR. WASHBURN: Thank you.

DIRECTOR MCRAITH: The court reporter will have originals, and we'll have a copy as well; is that right?

MR. WAGNER: That's correct.

DIRECTOR MCRAITH: So that we can provide you with a copy.

MR. WASHBURN: Thank you.

MR. WAGNER: Absolutely. And, Director, for your consideration is the -- just to clarify the record, changing the earlier marked ISMIE Mutual Insurance Company exhibit from Respondent's Exhibit to ISMIE Exhibit No. 1, and that is the -- those are the exhibits to date for your consideration for inclusion in the record.

DIRECTOR MCRAITH: Do we need to include

this?

MR. WAGNER: It's there.

DIRECTOR MCRAITH: Okay.

MR. WAGNER: That's all the exhibits. That's what we just ran through.

DIRECTOR MCRAITH: So do I need to accept your recommendation?

MR. WAGNER: Just order that they be included in the record if you're so inclined.

DIRECTOR MCRAITH: Please include those exhibits listed by Mr. Wanger in the official record of the hearing. Thank you. That's it for today.

(End of Hearing for 9-27-05.)

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

CERTIFICATE

I, Robin A. Adams, affiliated with Capitol Reporting Services, Inc., do hereby certify that I reported in shorthand the foregoing proceedings; that the interested parties were duly sworn by me; and that the foregoing is a true and correct transcript of my shorthand notes so taken as aforesaid.

I further certify that I am in no way associated with or related to any of the parties or attorneys involved herein, nor am I financially interested in the action.

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and Notary Public.

Dated this 4th day of
October, A.D., 2005,
at Springfield, Illinois.